DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 27, 2016

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator
Hawaii Medicaid Director
601 Kamokila Blvd., Suite 518
Kapolei, HI 96707

Dear Dr. Peterson,

I am pleased to inform you that your request to renew the Hawaii Section 1915(c) Home and Community-Based Services Waiver for People with Intellectual and Developmental Disabilities has been approved. The renewal has been assigned Control Number 0013.R07.00 and is approved with an effective date of July 01, 2016.

This five-year renewal continues to provide adult day health (ADH), discovery and career planning (DCP), individual employment supports, personal assistance/habilitation (PAB), residential habilitation (ResHab), respite, skilled nursing, assistive technology, chore, environmental accessibility adaptations, non-medical transportation, personal emergency response systems (PERS), specialized medical equipment and supplies, training and consultation, vehicular modifications, and waiver emergency services.

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

	Unduplicated Participants (Factor C)	Community Costs (Factor D+D')	Institutional Costs (Factor G+G')	Total Waiver Costs (Factor C x Factor D)
Year 1	**2735**	**$43,713.59**	**$123,823.48**	**$104,104,957.95**
Year 2	**2767**	**$43,829.92**	**$126,547.59**	**$105,300,979.67**
Year 3	**2799**	**$43,965.25**	**$129,331.64**	**$106,542,031.68**
Year 4	**2831**	**$44,106.96**	**$132,176.94**	**$107,793,750.51**
Year 5	**2863**	**$44,227.35**	**$135,084.82**	**$108,977,002.96**

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

We appreciate the cooperation of your staff during the review process. If you have any questions about this waiver renewal, please contact Adrienne Hall at (415) 744-3674 or Adrienne.Hall@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Madi Silverman, Med-QUEST Division, DHS
Aileen Manuel, Med-QUEST Division, DHS
Mary Brogan, Developmental Disabilities Division, DOH
Debra Tsutsui, Developmental Disabilities Division, DOH

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
1. CHANGES RELATED TO THE CMS FINAL RULE
Language throughout the application was modified to reflect the expectations of full community integration and person-centered planning. One new requirement added was that any new provider of the service must be in full compliance with the Final Rule before being enrolled and delivering services. The waiver transition plan activities outlined in Attachment #2 mirror the My Choice My Way State Transition Plan.

2. RESIDENTIAL HABILITATION ADDED
Residential Habilitation (ResHab) is a new service added back to this waiver renewal. It was an existing service until the last waiver renewal in 2011. It has been added to the service array again to better support shared living arrangements in licensed adult foster homes and to provide a daily payment, rather than hourly PAB services. There are no anticipated negative impacts to participants currently living in these shared arrangements.

3. ADDITIONS TO APPENDIX G
The DOH/DDD developed Policies and Procedures (P&P) that focused on positive behavior supports and interventions, defined interventions that are prohibited, specified the parameters under which permitted interventions are implemented. The P&P for Adverse Event Reporting was also revised and the waiver application reflects the P&P.

4. DISCOVERY AND CAREER PLANNING
This waiver application revised the existing Prevocational Service (PS) in two primary ways: 1) language was eliminated that stated that PS are provided to persons who are not expected to join the general workforce in one year as this was a potential barrier for people who may be able to enter the workforce sooner; and 2) the new service enables a participant to use the service once employed to explore other potential areas of employment if they want to change careers, to revise an existing career plan, or to work on general skills needed for advancement in their chosen career.

5. SKILLED NURSING
Skilled Nursing is a current service being revised to clarify terms.

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

1. Request Information (1 of 3)

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

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

3 years ◉ **5 years**

Original Base Waiver Number: HI.0013
Waiver Number:HI.0013.R07.00
Draft ID: HI.001.07.00

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*
07/01/16
Approved Effective Date: 07/01/16

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

Hospital as defined in 42 CFR §440.10
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160

☐ **Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

◉ **Not applicable**

Applicable
Check the applicable authority or authorities:

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

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

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

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

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose:

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

Goals/Objectives:

1) To provide necessary supports to participants in the waiver to have full lives in their communities and to maximize independence, autonomy and self-advocacy.

2) To evaluate and continuously improve the quality of services to participants, including measuring the satisfaction of the benefits and services the participants receive, in order to improve them.

Organizational Structure:

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

Authority:

The waiver will be implemented by the DOH/DDD under the supervision of the DHS/MQD. DHS/MQD exercises oversight and ultimate approval over DOH/DDD's implementation, administration and operation of the waiver program. DHS/MQD promulgates rules regarding the oversight and operational approval authority that are binding upon DOH/DDD. DHS/MQD retains ultimate responsibility for the waiver. DHS/MQD serves as the primary communication liaison with CMS and directly involves DOH/DDD in discussions pertinent to the waiver.

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

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

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

Not Applicable

No

◉ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

◉ **No**

Yes

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

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

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

5. Assurances

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

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal

supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
The State engaged in a consultative, open communication process across stakeholders throughout the development of the waiver application using multiple venues and forums to have discussions with waiver participants, families, advocates, providers, legislators, other state agencies, staff and other interested members of the public DOH/DDD and DHS/MQD prioritized public input continuously through the waiver renewal process, starting in August 2015 with a large all-day kickoff session across stakeholder groups on the island of Oahu. This well-attended session involved national experts, and break-out sessions that began the design of the waiver application. The session was attended by 117 people, including 12 self-advocates, 9 family members, and representatives from 26 organizations. During August and September 2015, additional "Talk Story" sessions were convened statewide in the more rural "neighbor islands", (Big Island-Kona, Big Island-Hilo, Maui, Molokai and Kauai). Nearly 100 people attended the neighbor island sessions (families, participants, case managers, advocates, providers, state staff and interested members of the public) that gathered input, concerns and ideas from the audience. The DOH/DDD has a dedicated email to receive feedback from the public that will continue to be available throughout the period of the waiver renewal for ongoing input. Feedback received was used to shape the service array and guide other revisions for the renewal application.

DOH/DDD and DHS/MQD met regularly with a number of organizations to obtain comment and input prior to and during the formal 30-day public notice and comment period. These groups included:

- Waiver Policy Advisory Committee (Waiver PAC), comprised of various stakeholders (individuals with I/DD, family members, providers, Developmental Disabilities Council (DD Council), DOH staff) Throughout the current waiver, DOH/DDD has met quarterly with this standing committee that has been instrumental in providing input used continuously to identify ways to improve the service system, as well as in the development of this waiver application. Throughout the years of the current waiver, the group discussed current and future services, gaps in services, rates, standards, staff qualifications, as well service delivery challenges and successes.

- Self-Advocacy Advisory Committee (SAAC) advocates for the rights of individuals with developmental disabilities to have a voice

in governmental and community affairs. The SAAC meets monthly and a representative from DOH/DDD, typically the peer mentor, attends these meetings to share information and gather feedback. The SAAC provides minutes from its meetings to DOH/DDD and pertinent issues are discussed with DOH/DDD and DHS/MQD staff.

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

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

The tribal notice was mailed to Ke Ola Mamo on December 28, 2015 and consultation began on December 30, 2015. Public notice was also provided in a newspaper publication and posted on the DHS/MQD website http://www.med-quest.us on December 30, 2015. The formal public notice and comment period was January 14, 2016 to February 15, 2016. The draft waiver application was posted on-line on the DHS/MQD website and the DOH/DDD website. Letters were mailed in December 2015, to each participant and their families that summarized the proposed changes to the renewal application and how to provide input (email, fax, phone, mail). Copies of the entire waiver application were available to participants and families via the website, and also through their case managers upon request. All providers received an email with the same information.

On January 13, 2016 (one day prior to the beginning of the formal public notice and comment period), DHS/MQD and DOH/DDD hosted informational sessions for participants, families, guardians, advocates, members of the public, providers and state staff that were in person and video conferenced statewide. Listening to public input statewide across stakeholder types allowed DHS/MQD and DOH/DDD to make the design of the waiver an iterative process, which allowed for successive drafts of the application to be reviewed by multiple groups multiple times. DOH/DDD received more than 150 comments during the formal public notice and comment period. Each comment was reviewed by DHS/MQD, DOH/DDD and the Hawaii State Council on Developmental Disabilities together to determine themes, potential issues and ways to strengthen the application.

Changes were made as a result of public comment and will be included in the section of the waiver. The complete public comment summary will be posted on the DHS/MQD website at http://www.med-quest.us/

Summary of public comments are in the Additional Needed Information Section (Optional) of this application.

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

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

7. Contact Person(s)

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

Last Name:	Mohr Peterson
First Name:	Judy
Title:	Med-QUEST Division Administrator
Agency:	Department of Human Services
Address:	601 Kamokila Boulevard, Suite 518
Address 2:	
City:	Kapolei
State:	**Hawaii**
Zip:	96709
Phone:	(808) 692-8050 **Ext:** ☐ **TTY**
Fax:	

(808) 692-8155

E-mail: JMohrPeterson@medicaid.dhs.state.hi.us

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

Last Name: Brogan

First Name: Mary

Title: Administrator, Developmental Disabilities Division

Agency: Department of Health

Address: 1250 Punchbowl Street, Room 463

Address 2:

City: Honolulu

State: **Hawaii**

Zip: 96813

Phone: (808) 586-5840 **Ext:** ☐ **TTY**

Fax: (808) 586-5844

E-mail: mary.brogan@doh.hawaii.gov

8. Authorizing Signature

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

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

Signature: Madi Silverman

State Medicaid Director or Designee

Submission Date: Jun 22, 2016

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Wong

First Name: Rachael

Title: Director

Agency: Department of Human Services

Address:

Address 2: 1390 Miller Street, Room 209

City: Honolulu

State: **Hawaii**

Zip: 96813

Phone: (808) 586-4993 **Ext:** ☐ **TTY**

Fax: (808) 586-4890

E-mail: dhs@dhs.hawaii.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☑ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☑ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This waiver renewal applications includes several changes by adding one service (Residential Habilitation), eliminating one service (Group Employment Supports), revising many of the existing services, and strengthening participant safeguards. None of the changes are expected to have a negative impact on the types of support participants receive per their Individualized Service Plan. The changes are primarily designed to clarify service definitions and bring focus to community integration activities.

SERVICES:
Services are grouped into categories that follow the list provided to participants, families and stakeholders prior to the public comment period.

Employment

1) Adult Day Health (ADH) is a current service being revised. Changes include adding participant choice and focus on outcomes related to community integration, changing to a 15-minute code to give participants the option to attend ADH on an individualized schedule instead of a half-day or full-day, and clarifying that ADH is not used for paid employment. This service will offer more community-based opportunities rather than center-based activities during the waiver renewal period as remediation activities will be required to meet compliance with the CMS Settings Rule.

2) Group Employment Supports is being eliminated at renewal.

3) Individual Employment Supports is a current service being revised. Changes include clarifying what is included in this service, the duties for job development, job coaching and adding customized employment. The new definition adds the requirement and definition for integrated employment at or above minimum wage. The clarifications and addition of customized employment will make it easier for participants to use this service.

4) Discovery and Career Planning (DCP) combines an existing service in the current waiver (Prevocational) with a new service (Career Planning) and changes the title. These revisions were the result of numerous public comments and brainstorming sessions with stakeholders to improve access to the services needed to help participants explore their interests and skills, enter the workforce and maintain employment. Many of the activities were in the previous service definition of Prevocational but needed to be expanded and clarified so

participants, families, guardians, and providers understand what is included for discovery, career planning and financial literacy.

Personal Assistance and Training/Habilitation

5) Personal Assistance/Habilitation (PAB) is a current service that is unchanged from the current waiver until an amendment is submitted following the completion of the rate study.

6) Residential Habilitation (ResHab) is a new service added back to this waiver renewal. It was an existing service until the last waiver renewal in 2011. It has been added to the service array again to better support shared living arrangements in licensed adult foster homes and to provide a daily payment, rather than hourly PAB services. There are no anticipated negative impacts to participants currently living in these shared arrangements.

7) Skilled Nursing is a current service being revised. Changes include clarifying definitions of terms. If any participants currently receiving Skilled Nursing would be impacted by this clarification in terms, no changes would be made to the current service authorization for a participant until a thorough assessment of needs is completed and a determination is made whether the participant's needs require Skilled Nursing to continue at the current level of services as an exception or if the participant's needs can be met by working toward a transition to other services or to the Health Plan.

Participant and Family Supports

8) Training and Consultation is a current service being revised. Changes include expanding the role of providers in monitoring, oversight and training of service supervisors and families. These changes were the result of numerous public comments and brainstorming sessions with stakeholders.

9) Respite is a current service with no changes made to this service.

Crisis/Emergency Services

10) Personal Emergency Response System is a current service. No changes were made in service except to separate cost of assessment and training in use of the system.

11) Waiver Emergency Services is a current service with a change to remove Crisis Respite based on no utilization and feedback from public input that participants and families may be using other existing services, such as Respite and PAB, rather than a crisis respite service.

Other Services

12) Assistive Technology is a current service. Minor changes were made to clarify what is covered and to separate cost of assessment and training in use of any items or devices. There is no anticipated negative impact to the changes.

13) Environment Accessibility Adaptations is a current service being revised to increase the limit of major home modifications because of the high cost of construction and remodeling in Hawaii, separate the cost for obtaining professional drawings and permits as required by rigorous city and county requirements, add parameters for the expected lifetime for modifications, clarify limitations and terms, and allow different adaptations within the same 5-year period when required for different purposes. This service also separates assessment and training in use of adaptations to be covered. The changes are intended to improve the process for obtaining home modifications for participants and their families.

14) Vehicular Modification is a current service being revised to increase the cost limit of modifications in a 5-year period because of the need to send vehicles out-of-state for adaptations, as well as to separate assessment and training in use of modifications covered. The changes are intended to improve the process for obtaining modifications to a vehicle.

15) Specialized Medical Equipment & Supplies is a current service with minor revisions to separate the assessment and training in use of any items/equipment.

16) Non-Medical Transportation is a current service being revised to add more public transportation options to support community integration.

17) Chore is a current service with minor revisions to improve readability but did not change the service definition.

Participants are provided a Notice of Action and information about requesting a DOH/DDD informal appeal, DOH/DDD formal appeal/administrative review and Fair Hearing for any reduction, suspension, denial or termination of waiver services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Hawaii assures that the settings transition plan included with this amendment will be subject to any provisions or requirements included in Hawaii's approved Statewide Transition Plan. Hawaii will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

HAWAII'S STATEWIDE TRANSITION PLAN

SUMMARY OF THE CMS HOME AND COMMUNITY BASED FINAL RULE
In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued new regulations that require home and community-based waiver services to be provided in community like settings. See www.medicaid.gov and search for home and community based services for a copy of the regulations. The new rules define settings and that are not community-like and after a transition period, those settings that do not meet the new rules cannot be used to provide federally-funded home and community based services (HCBS). The purpose of these rules is to ensure that people who receive home and community-based waiver services have opportunities to access the benefits of community living and receive services in the most integrated settings. States will be allowed a maximum of five years (until March 2019) to make the transition. Hawaii intends to implement its transition plan by July 2017. The requirements for submitting a transition plan to CMS rest with the single-state Medicaid agency. In Hawaii, the Department of Human Services, Med-QUEST Division (DHS/MQD) has taken the lead for meeting the requirements for the transition plan. Hawaii proposes the My Choice My Way transition plan with the following time table and deliverables to come into compliance with CMS' revised HCBS rules.

HAWAII'S MY CHOICE MY WAY ADVISORY GROUP
Hawaii's transition plan is called "My Choice My Way." DHS/MQD convened an advisory group called My Choice My Way to develop Hawaii's transition plan. Self-Advocacy Advisory Council (SAAC participates on the My Choice My Way advisory group. At the formation of the group, SAAC chose the name, My Choice My Way, for the transition plan and advisory group.

The Department of Human Services, Med- QUEST Division (DHS/MQD) is partnering with various organizations in Hawaii that includes SAAC, Special Parent Information Network (SPIN), Department of Health, Developmental Disabilities Division (DDD), Department of Health, Office of Health Care Assurance (DOH/OHCA), State Council on Developmental Disabilities (DD Council), Case Management Agencies, Hawaii Waiver Provider Association (HWPA), Adult Foster Homes of the Pacific, and Big Island Adult Foster Home Operators. These organizations represent Medicaid waiver participants, waiver families, provider associations, advocates, other State agencies, and other stakeholders throughout this process to develop the plan, receive input, and assure that everyone has access to needed information to assist with transition activities. The organizational structure for the My Choice My Way advisory group is below.

The MQD is committed to engaging with stakeholders through this process and looks forward to continuing to receive feedback. The outcome of this process will be that Medicaid waiver participants will receive services in a way that enables them to live and thrive in truly integrated community settings.

The My Choice My Way advisory group had its first meeting in October 2014. This advisory group has met at least monthly to develop the transition plan, review the public comments, and incorporate public comments into the transition plan. The My Choice My Way advisory group will continue to meet for implementation of the transition plan.

COMPONENTS OF THE MY CHOICE MY WAY TRANSITION PLAN
1. ASSESSMENT (both residential and non-residential settings)
Process for assessing and analyzing all HCBS settings for compliance
Individuals who have access to HCBS will have an opportunity to participate in assessing their settings
The assessment may be completed alone or with help from family/friends
Case managers and service coordinator may help complete assessment as well
Providers will be given an opportunity for self-assessment of their settings
State agencies perform an analysis of both individual and provider assessments
State agencies perform mandatory site validation visits for providers setting that may isolate
Update transition plan based upon assessments

2. REMEDIATION
Modify State Statutes, Rules, Standards, or Other Requirements to meet new HCBS rules
Inform providers of room for improvement to meet rules based upon assessments

State agencies submit justification for heightened scrutiny to CMS for settings that may isolate but are in fact HCBS and do not have the qualities of an institution
Develop operational procedures with providers to implement changes to meet new HCBS rules
Develop relocation plan for individuals that are in a setting that does not meet the new HCBS rules

3. KEY STAKEHOLDER ENGAGEMENT AND PUBLIC COMMENT
Posted a public notices and conducted comment periods- December 16, 2014 to January 30, 2015 and January 15, 2016 to March 1, 2016
Sent tribal consultation letters with draft transition plan was sent to Ke Ola Mamo- For December 12, 2014 and December 30, 2015- Ke Ola Mamo did not provide comments on the transition plan to MQD for the first and second public comment period
Public Forums held at the Queen's Conference Center Auditorium and streamed live through video teleconference (VTC) sites on neighboring islands- January 14, 2015 and January 14, 2016
Informational session held twice a year in January and July: one session will be for participants, families, advocates and the other for providers.

LOCATION OF THE MY CHOICE MY WAY TRANSITION PLAN
On the Med-QUEST website at www.med-quest.us News and Events section

SUMMARY OF PUBLIC COMMENTS
MQD received public comment from two public forums as well as through its formal public comment period. Attached is a copy of the newsletter that DHS/MQD posted on its website for the public forums. In addition, several organizations from the My Choice My Way advisory group distributed to their membership information about the forum to include SPIN, HWPA, DOH/DDD, DHS/MQD, and Case Management Agencies. DHS/MQD has copies of all of the public comments that we received for submission to CMS, if indicated. In addition, below is a summary of the public comments that DHS/MQD received since publishing its draft My Choice My Way transition plan as well as changes that DHS/MQD made to the transition plan based upon public comment. A table summary provides information on the comment type, date received, comment summary, state response, and impact on transition plan.

PUBLIC FORUMS
January 14, 2015 and January 14, 2016
Approximately 200 individuals statewide attended the public forum to include in person and video teleconference (VTC) sites on the following islands: Hawai'i (one in Hilo and one in Kona), Kaua'i, Maui, Moloka'i, O'ahu (one in person and one VTC). The attendees included waiver participants, their families, providers to individuals receiving HCBS, state agencies that provide services to waiver participants, and other stakeholders The first forum provided an overview of the HCBS rules and a summary of the draft transition plan. The forum provided an overview site validation visits. Attached is a copy of the presentation of the public forum. Afterwards the My Choice My Way advisory group (or panelists) answered questions from the attendees. For questions that were related to the transition plan, the panelists referred individuals to components of the My Choice My Way transition plan (i.e., process for assessments). Both events were moderated by Hilopa'a, Hawaii's Family to Family Health Information Center. Many of the questions in the first forum were not related to the My Choice My Way transition plan. The second forum provided a summary of updates on the transition plan and shared assessment results from validations.

PUBLIC COMMENTS
January 14, 2015 and January 14, 2016
DHS/MQD received public input from the first public forum as well as four written comments: one stakeholder organization, two parents, and one provider association. DHS/MQD received public input from the second public forum as well as 3 written comments: two stakeholder organization and one provider association. The My Choice My Way advisory group reviewed all of the public comments. My Choice My Way advisory group revised the transition plan to include additional steps to assure continued public input throughout implementation of the transition plan. The timeframes for several functions were delayed by a month to allow increased public input. DHS/MQD has posted a question and answer on its website that responds to all of questions posed through public comment process.

INFORMATION ON THE MY CHOICE MY WAY TRANSITION PLAN
Individuals may continue to obtain information on Hawaii's My Choice My Way transition plan or submit questions or comments to:

Website: www.med-quest.us News and Events section

Email: mychoicemyway@medicaid.dhs.state.hi.us

Mailing address:
Department of Human Services, Med-QUEST Division
Attention: Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

Telephone: 808-692-8094
Fax: 808-692-8087

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THE MY CHOICE MY WAY TRANSITION PLAN

The State of Hawaii has prepared this statewide transition plan in accordance with the new Home and Community Based Services (HCBS) regulations in 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2). This plan addresses settings where home and community based services are provided through the Med-QUEST Division's QUEST Integration program and the 1915(c) waiver for persons with intellectual/developmental disabilities. Hawaii's plan outlines the activities to be undertaken by the State in partnership with the individuals who receive home and community based services, their families, friends, advocates, providers, and other stakeholders. The State of Hawaii will implement this plan in a manner that assures the health and safety of the individuals receiving HCBS. In addition, this transition plan does not replace previous assessments that an individual receiving HCBS may have had. The plan is organized into three sections: Assessment, Remediation, and Stakeholder Engagement/Public Input. Action steps, time frames and the products of the steps are included with each area of the HCBS Plan.

SECTION 1: ASSESSMENT
This area focuses on two key areas: 1) a system-level analysis of the State's regulations, standards, policies, licensing requirements, and other provider requirements that ensure settings to ensure full and on-going compliance with the federal requirements; and 2) an analysis of settings where HCBS are delivered to assess readiness to meet the federal regulations. The Assessment Phase employs a number of strategies to fully assess and determine compliance

ASSESSMENT ACTIVITIES- RESIDENTIAL SETTINGS
Action Item: Review State standards
Description: State will review current statutes, rules, regulations, standards, or other requirements to identify any needed changes for full compliance with the HCBS settings requirements.
Proposed Dates: 10/17/2014 to 4/1/2015
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HRS, HAR, Waiver Standards, contracts, HCBS rules, CMS guidance
Outcome: Identify areas where current language needs to be strengthened or revised for full compliance with the HCBS settings requirements. A systemic assessment is submitted as a component of the transition plan

Action Item: Compile list of all licensed/certified homes where HCB services are provided
Description: Build database with information on every home that provides HCB services: Provider name, address, numbers of participants, names of HCBS participants by setting
Proposed Dates: 01/01/15 to 01/30/15
Responsible Agencies: DOH/OHCA, DOH/DDD
Key Stakeholders: My Choice My Way advisory group are the decision makers on the factors to gather
Sources/documents: DOH/DDD-OCB, DOH/DDD-CMB, DOH/OHCA
Outcome: Obtain a comprehensive list of all licensed/certified homes

Action Item: Develop process for settings analysis and identify the assessors
Description: My Choice My Way workgroup advises State on development of the process for assessing and analyzing all HCBS settings. Workgroup develops a matrix for determining settings for on-site visits. State is responsible for identifying assessors of selected sites. The public will have input into the process for setting
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Written process and training module for assessor. Share process and tools with providers.

Action Item: Develop the settings analysis tool
Description: The tool will assist in identifying current settings and classifying them into categories Category 1- Yes, meets requirements, Category 2- Not Yet, can meet with remediation, Category 3- No, cannot meet requirements and Category 4- Not yet, presumed not HCBS but State will require heightened scrutiny
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Share tool with providers. The setting analysis tool is submitted as a component of the transition plan.

Action Item: Revise transition plan to include assessment information as described below
Description: Transition plan will be updated to incorporate information found from assessment of providers and participants/consumers. Stakeholders will review transition plan for input.
Proposed Dates: 12/14/15 to 01/14/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Remediation phases of transition plan are updated to include additional information gathered from assessments.

Residential Participants/Consumers
Action Item: Develop the participant/ consumer experience survey

Description: HCBS participants and consumer advocacy entities will receive the survey. The survey will provide participant/consumer the opportunity to report their experience with their current HCBS settings.
Survey will: Formatted in larger font size (i.e., 18 point), include pictures, plain language, reading level, and referred to SAAC for input prior to issuing.
Proposed Dates: 01/01/15 to 02/01/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: Crosswalk document of NCI and HCBS Rule. Other states' surveys and CMS exploratory questions
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Select a statistically significant sample of HCBS participants
Description: The state will select a statistically significant sample of HCBS participants who live in provider-owned or controlled settings to complete the survey.
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN
Sources/documents: Compiled database stated above
Outcome: Identify a statistically significant sample of HCBS participants residing in provider- owned or - controlled settings. Method is submitted as a component of the transition plan.

Action Item: Conduct a participant/ consumer experience survey
Description: State will conduct an assessment using the Participant Experience Survey: Identify organization(s) that help participant/consumer complete survey (i.e., Case Management Agencies, DDD Case Managers, DD waiver agencies that do not provide residential services), utilize family members who have active contact with their relative to interpret the needs/experiences of non- verbal participants/consumers, ask SAAC to complete the survey, instructional memo prior to issuing, post form on-line to download in addition to mailing, add the survey to "survey monkey" for completion electronically, contact information for questions- e-mail and voice mail; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/05
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Participant survey- Training for organizations
Description: Training provided to organizations to help the participant to complete survey.
Proposed Dates: 03/01/15 to 03/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals assessing providers for compliance with HCBS settings will have training. The training presentation is submitted as a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request). Providers will be placed in a category of compliance.
Proposed Dates: 06/1/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Residential Providers
Action Item: Develop the provider self- assessment survey
Description: The survey will assist in identifying provider readiness and classifying them into categories identified in Assessment #4. The public will have input into the provider survey.
Proposed Dates: 01/01/15 to 03/31/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Identify providers who will complete self-assessment survey
Description: All providers will be given the opportunity to complete the Provider Self-Assessment Survey
Proposed Dates: 02/01/15 to 02/28/15

Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: Compiled database stated above
Outcome: Identified providers to complete assessment. Method is submitted as a component of the transition plan.
Action Item: Conduct a provider self-assessment survey
Description: Providers will conduct a self- assessment of settings using the Provider Survey: Instructional memo prior to issuing, post form on-line to download in addition to mailing, add the survey to "survey monkey" for completion electronically, contact information for questions- e-mail and voice mail; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request) Providers will be placed in a category of compliance.
Proposed Dates: 06/01/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Develop validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data.
Proposed Dates: 08/01/15 to 09/30/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals validating providers for compliance with HCBS settings will have training.

Action Item: Validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data. Reviewers utilized "Big Tent" as communication platform during the validation period. The website served as a discussion board and tracking tool which reviewers can view any validations that have been scheduled or already completed.
Proposed Dates: 10/08/15 to 10/08/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The training presentation is submitted as a component of the transition plan

Action Item: Validate the provider self- survey
Description: State staff or designee will conduct site visits to a sample of providers to validate findings in the provider survey and aggregate data. State identifies areas for remediation. (Validation Data is available upon request)
Proposed Dates: 10/15/15 to 12/11/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The validation tool is a component of the transition plan. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Conduct mandatory site visits for all category 4 settings
Description: State will perform a mandatory site visit to facilitate the heightened scrutiny process. Results of the visit will undergo public input prior to submission to CMS.
Proposed Dates: 01/2016 to 01/2016
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: State shall plan to provide explanation of how the setting meets HCBS settings requirements. A summary of all Category 4 settings with explanations is a component of the transition plan

ASSESSMENT ACTIVITIES- NON RESIDENTIAL SETTINGS
Action Item: Review State standards
Description: State will review current statutes, rules, regulations, standards, or other requirements to identify any needed changes for full compliance with the HCBS settings requirements.

Proposed Dates: 10/17/14 to 04/01/15
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HRS, HAR, Waiver Standards, contracts, HCBS rules, CMS guidance
Outcome: Identify areas where current language needs to be strengthened or revised for full compliance with the HCBS settings requirements. A systemic assessment is submitted as a component of the transition plan

Action Item: Compile list of all licensed/certified homes where HCB services are provided
Description: Build database with information on every home that provides HCB services: Provider name, address; numbers of participants; names of HCBS participants by setting
Proposed Dates: 01/01/15 to 01/30/15
Responsible Agencies: DOH/OHCA, DOH/DDD
Key Stakeholders: My Choice My Way advisory group are the decision makers on the factors to gather
Sources/documents: DOH/DDD-OCB, DOH/DDD-CMB, DOH/OHCA
Outcome: Obtain a comprehensive list of all licensed/certified homes

Action Item: Develop process for settings analysis and identify the assessors
Description: My Choice My Way workgroup advises State on development of the process for assessing and analyzing all HCBS settings. Workgroup develops a matrix for determining settings for on-site visits. State is responsible for identifying assessors of selected sites. The public will have input into the process for setting analysis.
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Written process and training module for assessor. Share process and tools with providers.

Action Item: Develop the settings analysis tool
Description: The tool will assist in identifying current settings and classifying them into categories: Category 1- Yes, meets requirements, Category 2- Not Yet, can meet with remediation, Category 3- No, cannot meet requirements, Category 4- Not yet, presumed not HCBS but State will require heightened scrutiny. The public will have input into the setting analysis tool.
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Share tool with providers. The setting analysis tool is submitted as a component of the transition plan.

Action Item: Revise transition plan to include assessment information as described below
Description: Transition plan will be updated to incorporate information found from assessment of providers and participants/consumers. Stakeholders will review transition plan for input.
Proposed Dates: 12/14/15 to 01/14/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DDD, DD
Sources/documents: HCBS rules, CMS guidance
Outcome: Remediation phases of transition plan are updated to include additional information gathered from assessments.

Non Residential Participants/Consumers
Action Item: Develop the participant/ consumer experience survey
Description: HCBS participants and consumer advocacy entities will receive the survey. The survey will provide participant/consumer the opportunity to report their experience with their current HCBS settings. Survey will: Formatted in larger font size (i.e., 18 point), include pictures, plain language, and reading level, and referred to SAAC for input prior to issuing.
Proposed Dates: 01/01/15 to 02/01/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: Crosswalk document of NCI and HCBS Rule. Other states' surveys and CMS exploratory questions
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Select a statistically significant sample of HCBS participants
Description: The state will select a statistically significant sample of HCBS participants who live in provider-owned or controlled settings to complete the survey.
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN
Sources/documents: Compiled database stated above
Outcome: Identify a statistically significant sample of HCBS participants residing in provider- owned or - controlled settings. Method is submitted as a component of the transition plan.

Action Item: Conduct a participant/ consumer experience survey

Description: State will conduct an assessment using the Participant Experience Survey: Identify organization(s) that help participant/consumer complete survey (i.e., Case Management Agencies, DDD Case Managers, DD waiver agencies that do not provide residential services), utilize family members who have active contact with their relative to interpret the needs/experiences of non- verbal participants/consumers, ask SAAC to complete the survey, instructional information when issuing, post form on-line (and through survey monkey) to download in addition to mailing, contact information for questions- e-mail and voice mail, self-addressed envelope to return to DHS/MQD; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Participant survey- Training for organizations
Description: Training provided to organizations to help the participant to complete survey.
Proposed Dates: 03/01/15 to 03/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals assessing providers for compliance with HCBS settings will have training. The training presentation is submitted as a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request). Providers will be placed in a category of compliance.
Proposed Dates: 06/01/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Non Residential Providers
Action Item: Develop the provider self- assessment survey
Description: The survey will assist in identifying provider readiness and classifying them into categories identified in Assessment #4. The public will have input into the provider survey.
Proposed Dates: 01/01/15 to 03/31/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Identify providers who will complete self-assessment survey
Description: All providers will be given the opportunity to complete the Provider Self-Assessment Survey
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: Compiled database stated above
Outcome: Identified providers to complete assessment. Method is submitted as a component of the transition plan.

Action Item: Conduct a provider self-assessment survey
Description: Providers will conduct a self- assessment of settings using the Provider Survey: Instructional memo prior to issuing, post form on-line to download in addition to mailing, add the survey to "survey monkey" for completion electronically, contact information for questions- e-mail and voice mail; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request) Providers will be placed in a category of compliance.
Proposed Dates: 06/01/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council

Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Develop validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data.
Proposed Dates: 08/01/15 to 09/30/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals validating providers for compliance with HCBS settings will have training.

Action Item: Validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data. Reviewers utilized "Big Tent" as communication platform during the validation period. The website served as a discussion board and tracking tool which reviewers can view any validations that have been scheduled or already completed.
Proposed Dates: 10/08/15 to 10/08/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The training presentation is submitted as a component of the transition plan

Action Item: Validate the provider self- survey
Description: State staff or designee will conduct site visits to a sample of providers to validate findings in the provider survey and aggregate data. State identifies areas for remediation. (Validation Data is available upon request)
Proposed Dates: 10/15/15 to 12/11/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The validation tool is a component of the transition plan. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Conduct mandatory site visits for all category 4 settings
Description: State will perform a mandatory site visit to facilitate the heightened scrutiny process. Results of the visit will undergo public input prior to submission to CMS.
Proposed Dates: 01/2016 to 01/2016
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: State shall plan to provide explanation of how the setting meets HCBS settings requirements. A summary of all Category 4 settings with explanations is a component of the transition plan

SECTION 2: REMEDIATION
The State must include remediation activities with timeframes for completion and the process for monitoring to assure that milestones are met as Hawaii moves toward full compliance with the HCBS Rule. Remediation will include revise administrative rules, provider standards, and training to assure compliance with revisions.

Action Item: Modify State standards
Description: State modifies statutes, rules, regulations, standards, or other requirements to identify any needed change for full compliance with the HCBS settings requirements.
Proposed Dates: 06/2015-10/2017
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: A systemic remediation is conducted. State standards are revised and are in full compliance with the HCBS rules requirements. A detailed remediation crosswalk is a component of the transition plan

Action Item: Issue site specific provider remediation letter for all category 4 settings
Description: State will issue a site specific provider remediation action letter for all category 4 settings. This process includes: Template letter for remediation, corrective action format, given 30 business days to respond with a corrective action plan; and required to attend mandatory trainings
Proposed Dates: 04/01/16 to 04/30/16
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers review the remediation requirements, develop a corrective action plan to meet the HCBS rules requirements, and attends all mandatory trainings.

Action Item: Issue provider remediation letter for all category 2 settings
Description: State will issue a remediation action letter for all category 2 settings. This process includes: Template letter for remediation and required to attend mandatory trainings
Proposed Dates: 06/01/2016 to 06/30/16
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers review the remediation requirements and attends all mandatory trainings.

Action Item: Develop operational procedures for compliance with revised State standards
Description: Identify areas within state standards that need changes to operational procedures for full compliance with the HCBS settings requirements. Through the systemic review and Category 1 settings- Use their operational practices as a guide for other providers for developing remediation Track and monitor proposed changes to the State standards while operational procedures are being developed
Proposed Dates: 01/2016 to 12/2016
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD
Council, Providers
Sources/documents: HCBS rules, CMS Guidance
Outcome: Operational procedures are developed. Assure that operational protocols provide guidance to the caregivers related to the change in regulations.

Action Item: Mandatory provider training on revised operational procedures
Description: State will train providers on operational procedures to meet compliance with the HCBS settings requirements. Process includes a "train the trainer" model components for ongoing training, focused on person centered planning; and obtain a training certificate of completion
Proposed Dates: 01/2017 to 10/2017
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers understand operational procedures and obtains a training certificate of completion. Certificate will be presented during annual review until state standards are fully implemented.

Action Item: Provider oversight and monitoring- Category 4 settings
Description: State will provide oversight over all providers during the remediation period by: Verifying that the provider accepted the corrective action plan and provides the State with a remediation action plan, monitoring all providers by licensing/certification reviews annually and tracking remediation efforts by attending mandatory trainings
Proposed Dates: 04/01/16 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Assure providers complete items stated in corrective action plan, maintain compliance with state standards, and attend all mandatory trainings.

Action Item: Provider oversight and monitoring- Category 1 and 2 settings
Description: State will provide oversight over all providers during the remediation period by: Monitoring all providers by licensing/certification reviews annually and tracking remediation efforts by attending mandatory trainings
Proposed Dates: 06/01/16 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Assure providers maintain compliance with state standards and attend all mandatory trainings.

Action Item: Provider qualifications for new enrollees
Description: New prospective providers will receive information and technical assistance on HCBS settings requirements.
Proposed Dates: 11/07/15 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Provider is in full compliance with the HCBS rules requirements prior to providing services once state standards are enacted.

Action Item: Relocation plan- Participants in a setting that cannot meet the HCBS requirements
Description: State develops a relocation plan for participants in settings that cannot meet the HCBS requirements. The responsible state agency issues a notification letter to the provider and the participant, case manager/service coordinator will discuss different setting options in a person centered planning meeting, participant/consumer and case manager/service coordinator will work collaboratively during transition to setting of choice
Proposed Dates: 10/2018 to Ongoing

Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Case manager/service coordinator and provider shall coordinate throughout transition process.

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SPECIFIC REMEDIATION STRATEGIES FOR THE HAWAII I/DD WAIVER

REVISIONS TO HAWAII ADMINISTRATIVE RULES:
Anticipated Date of Completion: 10/2017
Waiver participants reside in a number of different types of settings that have administrative rules or licensing requirements. DOH/DDD will coordinate revisions to the Hawaii Administrative Rules related to certified Adult Foster Homes for persons with DD. DOH/DDD will participate with the DOH Office of Health Care Assurance (OHCA) and DHS/MQD to licensing requirements.

REVISIONS TO THE MEDICAID WAIVER STANDARDS:
Anticipated Date of Completion: 9/2016
In order to ensure current and ongoing compliance with the HCBS requirements, Hawaii is reviewing and updating the Standards to reflect the HCBS requirements and other revisions related to this waiver renewal. The process includes stakeholders such as participants, families, providers, self-advocates and other community partners. DOH/DDD and DHS/MQD will revise the Standards to reflect the requirements for complying with the HCBS Final Rule.

REVISIONS TO DOH/DDD POLICIES AND PROCEDURES:
Anticipated Date of Completion: 12/2016
DOH/DDD, with approval of DHS/MQD, will develop policies and procedures that incorporate HCBS requirements.

REVISIONS TO NEW PROVIDER APPLICATIONS AND ORIENTATION:
Anticipated Date of Completion: 10/2016
DOH/DDD, with approval of DHS/MQD, has developed a checklist for any new provider applicant to evaluate its compliance with HCBS requirements at the time of enrollment. The checklist was based on the validation tool developed through the My Choice My Way Advisory Group. Additional revisions to the application are in process and will be used for any new applicant starting in July 2016. DOH/DDD will develop a new Orientation manual and offer training for prospective applicants to provide waiver services.

PROVIDER TRAINING:
Anticipated Date of Completion: 10/2017
DOH/DDD and DHS/MQD, in conjunction with the My Choice My Way Advisory Group, are designing mandatory training for providers whose settings are identified as Category 2 and 4. All-Provider meetings are held at least twice per year and general issues related to compliance with the HCBS Final Rule is a standing agenda item. Focused trainings will be provided related to provider-specific issues requiring remediation.

PROVIDER MONITORING FOR REMEDIATION AND ONGOING COMPLIANCE:
Anticipated Date of Completion: ongoing
The development of a provider corrective action plan is to ensure providers reach and maintain compliance with HCBS requirements. DOH/DDD will coordinator redesigning the monitoring tool and process for evaluating providers, including the addition of new strategies such as reviewing the benchmarks identified in the provider's remediation action plan, observations in the community and interviews with participants and families. Train state staff monitoring the providers to implement new strategies.

DEVELOP PROCESS FOR PROVIDER SANCTION AND DISENROLLMENTS
Anticipated Date of Completion: 6/2018
In the event the provider has gone through remediation activities and continues to demonstrate non-compliance with HCBS requirements, the state will develop a specific process for issuing provider sanctions up to disenrollment. This process is needed to ensure statewide compliance with HCBS requirements. The state will include stakeholders in discussions to develop the process. DOH/DDD and DHS/MQD will hold a formal public comment period to disseminate information on the provider sanctions and disenrollment criterion and to receive feedback from stakeholders.

SECTION 3: KEY STAKEHOLDER ENGAGEMENT AND PUBLIC COMMENT
Hawaii will use a transparent and robust stakeholder engagement process to provide information and gather input throughout the process of developing the transition plan and its implementation. Stakeholders were included on the My Choice My Way workgroup and are instrumental in developing the action steps, timeframes, and outcomes. DHS/MQD will announce the 30-day public comment period through website, newspaper, and public forum. DHS/MQD will retain all comments for future review.

Action Item: Announcement of public comment period
Description: Post the announcement in at least two forms. One will be public notice in newspapers, one will be public forum at Queen's conference center, recommend press release to Director's office, public announcements will occur, as needed, when there are significant changes to the transition plan
Proposed Dates: 12/16/14 to 1/30/15 and 12/30/15 to 03/01/16
Responsible Agencies: DHS/MQD

Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan supporting documentation
Outcome: DHS/MQD obtains comments from stakeholders on its proposed transition plan

Action Item: Tribal council requirements
Description: Assure that tribal council requirements are met. Tribal consultation will occur, as needed, when there are significant changes to the transition plan
Proposed Dates: 12/12/14 to 01/15/15 and 12/30/15 to 03/01/16
Responsible Agencies: DHS/MQD
Key Stakeholders: Ke Ola Mamo
Sources/documents: Tribal consultation letter and draft transition plan
Outcome: DHS/MQD obtains comments from Ke Ola Mamo on its proposed transition

Action Item: Posting on website
Description: My Choice My Way will determine website where documents will be posted for review by public. Websites include: DHS/MQD, DOH/DDD, SPIN (website and Facebook page), and SAAC (Facebook page)
Proposed Dates: 11/14/14 to Ongoing
Responsible Agencies: DOH/DDD, DHS/MQD, DD council, SAAC, SPIN
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan documents
Outcome: Documents posted and updated as needed. Web page hyperlinks make navigation easy

Action Item: Develop summary of transition plan
Description: Develop summary of transition plan document for communication to participants, consumers, families, and advocates. Formatted in larger font size (i.e., 18 point), include pictures; plain language; reading level and referred to SAAC for input prior to issuing.
Proposed Dates: 12/08/14 to 01/07/15 and 07/30/15 to 01/14/16
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Summary of transition plan
Outcome: The summary of transition plan will be modified to a document that can be used in training and education.

Action Item: Public forum
Description: My Choice My Way shares the transition plan with stakeholders in a public forum (Statewide) to provide information and answer questions. Queen's conference center, include ASL interpreter, include amplifying devices, as needed and public forums will be held, as needed, when there are significant changes to the transition plan
Proposed Dates: 01/14/15 to 1/14/15 and 01/14/16 to 01/14/16
Responsible Agencies: My Choice My Way workgroup
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan documents
Outcome: DHS/MQD provides information to the public on the transition plan and is able to address questions from the community.

Action Item: Compile and retain public comments
Description: State will compile and summarize all comments and retain all public input per CMS requirements
Proposed Dates: 01/30/15 to Ongoing
Responsible Agencies: DHS/MQD
Key Stakeholders: DHS/MQD
Sources/documents: Transition plan documents
Outcome: Submit public comment summary as a component of the transition plan

Action Item: Revise transition plan as needed based on public comments
Description: Based on public comments, the state may revise the statewide transition plan to address comments.
Proposed Dates: 02/01/15 to 03/15/15 and 03/01/16 to 3/15/16
Responsible Agencies: My Choice My Way workgroup
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Public comments summary
Outcome: Transition plan is revised as needed or additional evidence/rationale for state's decision if contrary to public comment.

Action Item: Develop communication channels for stakeholders
Description: Establish communication procedures, including by email and phone, for stakeholders to get questions answered with Frequently Asked Questions document compiled. Set up My Choice My Way e-mail account, determine one telephone number to call with questions, one primary way to receive comments, and compile Q&A for posting on websites identified above
Proposed Dates: 11/14/14 to Ongoing
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan documents

Outcome: Mechanisms in place for responding to stakeholder questions, and compiling Frequently Asked Questions.

Action Item: Assure public input into all aspects of the process of implementing HCBS rules
Description: Establish mechanism to obtain input through the process of implementation of the HCBS rules. Develop e-mail list of individuals interested in implementation of the HCBS rules, provide updates to individuals as opportunities to provide public comment occur, and maintain updated information on the Med-QUEST Division website throughout implementation of the HCBS rules
Proposed Dates: 2/2/15 to Ongoing
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers, other stakeholders
Sources/documents:
Outcome: Mechanisms in place for obtaining public input throughout the process of implementing the HCBS rules. Detailed process for public input is a component of the transition plan

Action Item: Information sessions with participants, families, and advocates
Description: State and its partners will conduct informational sessions with waiver participants, families, and advocates that include in-person, webinar sessions, and written information, Understanding the final rule and how it may or may not effect waiver services, overview of Hawaii's proposed HCBS Transition Plan and how it will guide the path forward toward full compliance, and encourage participation during periods of public input.
Proposed Dates: Every 6 months to 01/2019
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: On an ongoing basis, those affected by the revised HCBS setting rules will have an opportunity to receive updated information. The presentation is a component of the transition plan

Action Item: Information sessions with providers
Description: State will conduct informational sessions, training and technical assistance opportunities for providers. Provider training and technical assistance include in- person, webinar sessions, and written information, understanding the final rule and how it may or may not effect waiver provider services, overview of Hawaii's proposed HCBS Transition Plan and how to achieve and maintain full compliance, and encourage participation during periods of public input.
Organizations that have expressed interest include: Case Management Agencies, Community Care Foster, Family Home Association(s), Hawaii Waiver Providers Association (HWPA), Adult Residential Care Home Association(s)
Proposed Dates: Every 6 months to 01/2019
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: On an ongoing basis, providers will have an opportunity to receive updated information on HCBS rules. The presentation is a component of the transition plan

Acronyms
CMS- Centers for Medicare & Medicaid
CMB- Case Management Branch, DDD
CTA- Community Ties of America, Inc.
DOH- Department of Health
DDC- Hawaii State Council on Developmental Disabilities
DDD- Developmental Disabilities Division
DHS- Department of Human Services
HAR- Hawaii Administrative Rule
HCBS- Home and Community Based Services
HRS- Hawaii Revised Statutes
HWPA- Hawaii Waiver Provider Association
MQD- Med-QUEST Division
OHCA- Office of Health Care Assurance
SAAC- Self-Advocacy Advisory Council
SPIN- Special Parent Information Network

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Summary of Public Comments

The State received approximately 200 comments during the public notice and comment period. A summary of all comments was compiled and will be available on the DHS/MQD website. Following is a summary of comments that resulted in changes to the waiver.

1. COMMENT:
One provider expressed concern about limits on participants performing work at a waiver program.

ADH excludes... - How will it impact participants who do chores around the program site?
a. Stocking supplies, shredding paper, sweeping floors, etc.

STATE RESPONSE:
The State appreciates the provider's feedback and follow-up by phone discussion to better understand the types of situations being described. The intent of the language was to ensure that participants were not being used to perform work that they can complete independently and for which another worker would otherwise be paid to perform that job. In addition, clarification was needed to permit routine chores that are part of participating in a program.

IMPACT ON WAIVER:
The waiver language was revised. ADH limits state that ADH excludes: "2) supporting participants who independently perform activities that benefit the provider or its staff, i.e., independently doing services that would otherwise require the provider or its staff to pay for that service, such as landscaping, yard work, painting and housecleaning. This does not include routine chores and activities that participants engage in to maintain their common areas, practice responsibility and teamwork."

2. COMMENT:
Four commenters submitted questions and concerns about coordination of services between Adult Day Health, Discovery & Career Planning, and Individual Employment Supports for responsibility to transport the participant to and from services.

Employment Supports: Difference between transportation between employment activities and transportation to and from work. Does this mean the provider is responsible for the cost of transportation to and from work for the participant? Can non-medical transportation be used?

Non-Medical Transportation- Can this be used to get bus passes for public transportation?

Primary and alternate transportation need to be documented. ADH is responsible for transportation services, but the focus should be on public transportation, natural supports (meaning that ADH is not providing the transportation), and free community services (not currently available). Comments about transportation seem cumbersome and not realistic. Please provide a list of transportation.

STATE RESPONSE:
The State agrees with the commenter who raised the issue of fostering independence to get to work rather than relying solely on a waiver provider for that support on an on-going basis. The waiver service definition for Individual Employment Services was changed to use the term "arrange" for transportation, rather than "provide" transportation. This enables the participant and employment supports provider to collaborate on the participant's progress toward identifying, securing, and using other modes of transportation to and from work, while increasing independence and reducing reliance on public services. The Waiver Standards will be revised to clarify that participants may use Non-Medical Transportation to get to and from the job as specified in the participant's ISP and in compliance with the service description and limits. Proposed language in the waiver to identify other options for transportation (primary and secondary) was intended to support more variety in transportation to participate in community integration activities; however, the language was confusing and the commenter raised a concern that transportation responsibilities could be shifted from the ADH provider to natural supports. The State agreed with that comment and removed language related to natural supports and free community services.

IMPACT ON WAIVER:
The service description for Individual Employment Services was modified based on public input to require the provider to "arrange" rather than "provide" transportation to and from the participant's employer.

The service description for Adult Day Health was revised to return the language to that in the current waiver, which requires that the ADHs continue to be responsible for transportation.

3. COMMENT:
Two providers identified unclear language in the service description of Discovery and Career Planning and Individual Employment Supports.

What is the difference between Job discovery and job development?

Does DCP do both or is development an IES?

STATE RESPONSE:
The State agrees with the commenters and appreciates the thorough review. The Discovery & Career Planning service description had inadvertently included job development language that should have been under Individual Employment Supports.

IMPACT ON WAIVER:

Job development language was moved to Individual Employment Supports. Job discovery remained in the Discovery & Career Planning service description. Definitions of the terms "job discovery" and "job development" will be included in the Waiver Standards to further clarify the different activities.

4. COMMENT:
A number of commenters requested clarification on differences between Adult Day Health and Discovery & Career Planning. In the proposed language, employment-related "soft skills" such as professional appearance, timeliness, etc. were included in both service descriptions, leading to confusion about which service the participant should use.

The participant must receive services from two provider agencies, one for ADH and one for DCP?

Page 53 states that a participant's ISP could include both, while page 55 states that the "participant can choose to receive skills training through ADH waiver provider or through DCP waiver provider, but not from both during the same authorization period."

There needs to be more clarification regarding ADH and Discovery & Career Planning (DCP).

What if the participant just does not wish to work? The requirement for employment services listed in ADH (either working toward employment, retirement, or reason for exception specified in ISP) needs to reflect more personal choice.

STATE RESPONSE:
The State agrees with the commenters that the "boundaries" between the two services were overlapping and has revised language in the waiver to reflect that ADH focus is on individual independence, increased participation in the community and other skill building that leads to increased community integration. Discovery & Career Planning focuses on general workplace skills and exploring career paths.

IMPACT ON THE WAIVER:
The service description for ADH removed "movement to integrated competitive employment" and added "and other skill building that leads to increased community integration." The following sentence was removed from the ADH service description and: "ADH does not include training in skills for a specific job but rather focuses on generic job and workplace skills. Such training is not a prerequisite for employment as many participants can benefit from learning these types of skills on-the-job." Training in these generic job and workplace skills is in the Discovery & Career Planning service.

5. COMMENT:
A number of comments were received that focused on transportation issues unique to the Neighbor Islands. The following comments are representative of issues identified in this area that included Non-Medical Transportation.

From providers:
I am expressing concern I personally have. I wanted to ensure you are aware of the transportation issues we face. Much of our Island has NO public transportation. Where we are in Honokaa and all along the Hamakua and Kohala coast there is not even a taxi service available. This is true for the majority of our Island.

We try hard to accommodate the choices of our population by providing mileage to the DSW's. Obviously with the costs to the organizations constantly on the rise, this becomes increasingly challenging. We don't have the cheaper, public transportation as an option. I know our Island is unique, partly due to our sheer size, please take into consideration these challenges when you delegate funding for these new programs as well as the ones we already have.

[Non-Medical Transportation] - Could the $1000 cover para-transit rides, if offered in rural areas? On Kaua'i para-transit rides cost $2 for the participant and no charge for the aide. The most important modification would be the annual limit of $1000 when utilizing this service. In a rural area the cost of taxi use regularly would not be cost efficient and exceed the annual limit readily.

We agree that services in the community should be in a manner that will help our clients develop new skills, such as navigating their local community via public transportation. On Oahu, there are multiple options available. However, the Neighbor Islands it is very limited.

Transportation continues to be an important issue and perhaps an analysis on cost should be done by county.

From family members:
Non-Medical Transportation More Coordinating & Innovative initiatives need to be with Local Gov't Agencies to insure PROMPT & Appropriate deliveries of Services to & for Clients...

STATE RESPONSE:
As noted in the response to Comment #2, the comprehensive rate study will be looking at differences in geographic regions (county) and additional requirements such as administrative costs of training. Stakeholders will have several opportunities to provide feedback on the findings and rate model(s) through an informal public comment period and formal public notice and comment.

The State determined that the proposed limit should be removed in the waiver service definition for Non-Medical Transportation and will be reviewed during the rate study. If a limit is added to the service description, it will be included in a waiver amendment.

DHS/MQD and DOH/DDD will continue to foster partnerships and collaborate with other agencies and the community members to identify creative strategies to address transportation challenges, particularly on the Neighbor Islands.

IMPACT ON WAIVER:
The proposed annual limit of $1000.00 was removed. Once the rate study is completed, the State will make a policy decision whether a limit and if so, what amount, should be implemented. An amendment to the waiver will be submitted to the Centers for Medicare and Medicaid Services (CMS) once the rate study has been completed and decisions are made based on the findings and recommendations, as well as the public comments received.

6. COMMENT:
Several stakeholders commented on the revised definition, with some supporting a focus solely on behavioral supports while others wanted the qualified providers who could offer T&C to include other disciplines beyond those focused on behavioral supports.

From providers:
We are pleased to see that the Department of Health – Developmental Disabilities Division (DOH –DDD) has added modifications to the Training and Consultation Service and has recognized the need to focus this service on behavioral consultation and supports.

Additionally, we would like to acknowledge the DOH – DDD for including services that are evidence-based and best practice to support individuals who are exhibiting challenging behaviors.

From family members:
Where is PT? My [loved one] has a wheelchair and needs therapy.

STATE RESPONSE:
Based on the comments, the State determined that changing this service to focus solely on behavioral supports could potentially eliminate needed services that are provided by other disciplines such as physical, occupational and speech therapy. The current waiver permits T&C by a number of different professionals and leaving that intact with the renewal allows access to the various professionals, including those with expertise in behavioral analysis. This change does not impact the best practices noted by the commenter to provide ongoing monitoring of the implementation of the goals and outcomes.

IMPACT ON WAIVER:
Language was modified in the waiver application to add the following sentence: "Consultation activities are provided by professionals in psychology, nutrition occupational therapy, physical therapy, speech and language pathology, psychiatry, and behavior analysis." The following sentence was deleted: "Training and consultation services are focused on providing consultative supports for participants who experience challenging behaviors, their families, caregivers, staff and others who interact with the participant frequently."

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the State Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:
Department of Health, Developmental Disabilities Division

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Department of Human Services, Med-QUEST Division (DHS/MQD), as the Single State Medicaid Agency, administers all Medicaid waiver programs for Hawaii. In this capacity, DHS/MQD serves as the State's source for all matters pertinent to Medicaid. DHS/MQD provides technical consultation on issues relevant to Medicaid and Medicaid waiver to the Department of Health, Developmental Disabilities Division (DOH/DDD), which is the Waiver Operating Agency. DOH/DDD operates the waiver in accordance with the Memorandum of Agreement between DHS/MQD and DOH/DDD. The agreement is reviewed at least every five years aligned with the waiver renewal cycle and revisions are made if necessary.
DHS/MQD ensures the proper and efficient implementation of the waiver through the following:

1) Quality Assurance Reviews

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

Remediation and improvement activities may be participant and/or system focused. Anticipated outcomes include improvements to case management and participant service planning, recruitment and training of providers and increasing the ability of DOH/DDD to effect needed improvements and changes. Concerns specific to individual participants reviewed are referred to the DOH/DDD case manager for remediation and follow up, with quarterly performance measure reports provided to the DHS/MQD. Depending on the severity and intensity of situations reviewed, the issue may be elevated to a cross department executive level discussion and remediation. Corrective actions vary according to the scope and severity of the identified problem.

2) DHS/MQD Management Compliance Reviews

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

3) Regular Management Meetings between DHS/MQD & DOH/DDD

These "Collaboratives" are used to facilitate more effective communication between the oversight and operating agencies. Discussion topics include areas of concern identified by either DHS/MQD or DOH/DDD during their quality

assurance processes, strategies to improve services or mitigate problems, and strategies to improve existing services and processes. Issues are addressed as identified, leading to new processes or procedures, and follow-up discussions to monitor that implementation occurred.

4) Transition Plan Meetings between DHS/MQD, DOH/DDD, & My Choice My Way Advisory Group

This is used to facilitate more effective communication between the Medicaid agency, operating agency, and the My Choice My Way advisory group on a monthly or more frequent basis as needed. Discussion topics include the implementation of the new Home and Community Based settings requirements, transition plan remediation activities, and ongoing provider monitoring. Issues are addressed as identified, leading to new processes or procedures, and follow-up discussions to monitor that the implementation occurred.

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:* DHS/MQD has two contracts that perform operational or administrative functions for the waiver on behalf of the Medicaid agency.

1) DHS/MQD contracts its Fiscal Intermediary (FI) functions to XEROX for the Medicaid Agency's fee-for-service (FFS) program. The waiver program providers bill XEROX for payment.

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
XEROX
XEROX submits reports to DHS/MQD on a weekly basis. DHS/MQD monitors XEROX's performance through review of these weekly reports.

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
#/% of waiver policies/procedures developed or revised during the waiver year by DOH/DDD and approved by DHS/MQD. N: # of waiver policies/procedures developed or revised that are submitted during the waiver year by DOH/DDD and approved by DHS/MQD D: Total # of waiver policies/procedures developed or revised that are submitted during the waiver year

Data Source (Select one):
Other
If 'Other' is selected, specify:
DOH/DDD policies/procedures and Waiver standards

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of new waiver applicants determined to be eligible for waiver services within 90 calendar days of receipt of a completed application. N: # of new waiver applicants determined to be eligible for waiver services within 90 calendar days of receipt of a completed application D: Total # of new waiver applicants determined to be eligible for waiver services in the quarter

Data Source (Select one):
Other
If 'Other' is selected, specify:
DOH/DDD Applications tracking log

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of utilization reviews conducted by DOH/DDD in accordance with waiver approved policies/procedures. N: # of utilization reviews conducted by DOH/DDD in accordance with waiver approved policies/procedures D: Total # of utilization reviews conducted by DOH/DDD

Data Source (Select one):
Other
If 'Other' is selected, specify:
DOH/DDD Utilization Review tracking log

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver reports submitted by DOH/DDD and received by DHS/MQD in accordance with schedule N: # of waiver reports submitted by DOH/DDD and received by DHS/MQD in accordance with schedule D: Total # of waiver reports required to be submitted by DOH/DDD to DHS/MQD

Data Source (Select one):
Other
If 'Other' is selected, specify:
Scheduled reports from DOH/DDD

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of of scheduled validation activities completed by DHS/MQD N: # of scheduled validation activities completed by DHS/MQD D: Total # scheduled validation activities to be completed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Scheduled validation activities

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☐ **Continuously and Ongoing**
☐ **Other** Specify:

Performance Measure:
#/% of new approved waiver providers in full compliance with the HCBS settings requirements prior to service delivery N: # of new approved waiver providers in full compliance with the HCBS settings requirements prior to service delivery D: Total # of new approved waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Scheduled reports from DOH/DDD

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

	☐ **Other** Specify:

Performance Measure:
#/% of waiver provider that are in full compliance with the HCBS settings requirements N: # of waiver provider settings that are in full compliance with the HCBS settings requirements D: Total # of waiver provider settings

Data Source (Select one):
Other
If 'Other' is selected, specify:
Scheduled reports from DOH/DDD

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver providers in HPMMIS with a valid Medicaid provider agreement N: # of waiver providers in HPMMIS with a valid Medicaid provider agreement D: Total # of waiver providers in HPMMIS

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Audit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Xerox	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHS/MQD is responsible for program monitoring and oversight. Identified problems are reviewed within appropriate quality committees to resolve issues timely and effectively. Corrective action plans and other remediation activities are logged and tracked and information is shared between DHS/MQD and DOH/DDD at regular scheduled meetings.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			

☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

HRS § 333F-1 defines intellectual disability as follows: "'Intellectual disability' means significantly sub-average general intellectual functioning resulting in or associated with concurrent with moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period."

HRS § 333F-1 defines developmental disabilities as follows: " 'Developmental disabilities' means a severe, chronic disability of a person which:
1) is attributable to a mental or physical impairment or combination of mental and physical impairments;
2) is manifested before the person attains age twenty-two;
3) is likely to continue indefinitely;
4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
5) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

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

◎ **Not applicable. There is no maximum age limit**

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

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

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◎ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2735
Year 2	2767
Year 3	2799
Year 4	2831
Year 5	2863

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

The State limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	

Year 5	

Appendix B: Participant Access and Eligibility

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

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

◎ **Not applicable. The state does not reserve capacity.**

The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◎ **The waiver is not subject to a phase-in or a phase-out schedule.**

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

Select one:

◎ **Waiver capacity is allocated/managed on a statewide basis.**

Waiver capacity is allocated to local/regional non-state entities.

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

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

Individuals are admitted on a first-in, first-out basis. Exceptions to this order of admission as defined in the Hawaii Disability Rights Center Settlement Agreement (2005) will be made only for:

- an individual who requires crisis-level services in order to avoid institutionalization (persons who require crisis-level services are those for whom there are no supports available so that their health, safety and/or welfare are at risk); or

- an individual (or his/her legal guardian if applicable) who chooses to receive HCBS from a specific individual or provider and that individual or provider is not able to immediately provide services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:

§1634 State

SSI Criteria State

◉ **209(b) State**

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

◉ **No**

Yes

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☐ **SSI recipients**

☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional State supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

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

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

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

Check each that applies:

☐ **A special income level equal to:**

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☒ **Aged and disabled individuals who have income at:**

Select one:

◉ **100% of FPL**

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Optional State Supplement participants.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**

(Complete Item B-5-c (209b State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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

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

◉ **The following standard included under the State plan**

(*select one*):

The following standard under 42 CFR §435.121

Specify:

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

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)
A percentage of the FBR, which is less than 300%

Specify percentage:
A dollar amount which is less than 300%.

Specify dollar amount:

◎ **A percentage of the Federal poverty level**

Specify percentage: 100

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

◎ **Not Applicable**

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

Specify:

Specify the amount of the allowance (*select one*):

The following standard under 42 CFR §435.121

Specify:

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

◎ **Medically needy income standard**

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◎ **The State does not establish reasonable limits.**

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

◉ **A percentage of the Federal poverty level**

Specify percentage: 100

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

◉ **Allowance is the same**

Allowance is different.

Explanation of difference:

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

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

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

◉ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. **Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

   The provision of waiver services at least monthly

   ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

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

   Directly by the Medicaid agency

   By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

◎ **Other**
Specify:

DHS/MQD performs initial ICF-IID level of care (LOC) evaluations. DOH/DDD performs reevaluations.

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

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

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

a) As part of the initial evaluation, the following information is reviewed:
- DHS 1150C form documenting DOH/DDD recommendation and request for level of care authorization;
- physicians' recommendation completed and signed by the applicant's physician;
- results of any adaptive functional assessments;
- Psychological evaluation if performed;
- intake reports documenting personal/medical/family/social history, if no psychological evaluation is attached; and
- cognitive scores.

b) As part of the annual reevaluation, the following information is reviewed:
- annual physician recommendation completed and signed by the participant's physician;
- provider reports;
- in-person interviews by DOH/DDD case manager;
- services planning assessment(s), e.g., Inventory for Client and Agency Planning (ICAP), Supports Intensity Scale (SIS);
- adaptive functional assessment, e.g., Adaptive Behavioral Assessment System (ABAS);
- Individualized Service Plan (ISP); and
- updated psychological evaluation if performed for children, or for participants with mild-moderate intellectual disability, or for participants with major health changes whose cognitive and/or adaptive functioning may have changed.

The following criteria is used to determine when the adaptive functional assessment must be updated:
1. the ICAP score >80;
2. the current adaptive functional assessment is unclear;
3. cognitive and/or adaptive functioning has changed significantly; or
4. health has undergone major changes.

An updated psychological evaluation or updated testing is required when:
1. the adaptive functional assessment does not meet criteria (i.e., ABAS is in the mild range); and
2. for children at certain age groups with both IQ and adaptive scores in the mild to moderate range.

Based on analysis of the assessment results and additional information obtained, a determination is made whether the participant continues to meet eligibility for waiver services.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

◎ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

The DHS 1150 (facility) form is different from the DHS 1150C (waiver) form in that the DHS 1150 evaluates an individual's need for active treatment 24 hours/day, 7 days a week.

In both the initial evaluation and the annual re-evaluation, the types of core evaluations that are reviewed are the same (physician's recommendation or physician evaluation, psychological evaluations if performed, results of any adaptive functional assessments, cognitive scores, other reports that are available at the time of the initial or the re-evaluation). The outcomes are equivalent by virtue of the same methodologies used; the additional documents reviewed are only supplemental in nature and do not influence the outcome. As well, both processes require a review by the same Clinical Interdisciplinary Team (CIT) which reviews the same set of core documents if it is determined that the applicant/participant may not meet the level of care criteria or if the determination is questionable. If the CIT determines that the participant does not meet LOC, that recommendation is reviewed by the DHS/MQD Medical Director, who also reviews all initial LOC determinations. In FY2016 (quarters 1, 2 & 3 data), the CIT determined that two (2) participants did not meet LOC and both were validated by the DHS/MQD Medical Director.

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

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

a) Initial evaluation:
DOH/DDD has responsibility for obtaining and reviewing the required documentation, that includes at a minimum:
1) application requesting services;
2) physician's recommendation; and
3) adaptive behavior assessments identifying functional levels.

A psychological evaluation of cognitive and adaptive functioning by a licensed psychologist will be required if the physician's evaluation indicates a diagnosis of intellectual disability (ID).

Additional information such as Department of Education assessment reports may be requested by DOH/DDD.

Based on the review, DOH/DDD determines whether the applicant meets criteria as defined by HRS Chapter 333F-1. If the applicant meets the criteria and is Medicaid eligible, DOH/DDD recommends to DHS/MQD that the applicant be evaluated as meeting the ICF-IID LOC. The recommendation is documented on the DHS 1150C form.

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

DHS/MQD reviews the DHS 1150C form and attachments and determines the ICF-IID LOC. If the applicant meets LOC, the applicant is admitted into the waiver. If denied and not admitted into the waiver, DHS/MQD issues a Notice of Action to the applicant, stating the denial and the right to appeal.

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

b) Reevaluation:
Annually, the DOH/DDD reevaluates the participant's waiver eligibility using available information such as quarterly DOH/DDD case management reviews, provider reports, in-person interviews, the services planning assessment(s), e.g. Inventory for Client and Agency Planning (ICAP) or Supports Intensity Scale (SIS), the adaptive functional assessment, e.g. Adaptive Behavioral Assessment System (ABAS), the Individualized Service Plan (ISP), as well as the annual physician's evaluation. A psychological evaluation will also be updated for children, for participants with mild-moderate intellectual disability, or for participants with major health changes whose cognitive or adaptive functioning may have changed. The DOH/DDD Case Management Unit supervisor determines whether the participant meets LOC. The LOC of participants whose cognitive or adaptive functioning may have changed (i.e. children, participants with mild ID and/or mild deficiencies in adaptive functioning, or participants with major health changes) are reviewed and determined by the DOH/DDD Clinical Interdisciplinary Team (CIT). The LOC reevaluation is maintained in the participant's file.

The DOH/DDD case management unit supervisor, following the case manager's recommendation determines whether the participant meets LOC. If the participant's cognitive and adaptive functioning are unclear, a referral is made to the DOH/DDD clinical team for a determination. Any participant who does not meet LOC is reviewed by the clinical team as well as the DHS/MQD medical director prior to being discharged from the waiver. DOH/DDD provides the participant and/or guardian (if applicable) with a Notice of Action (NOA) stating the adverse action and the right to appeal to DOH/DDD and DHS/MQD.

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

Every three months

Every six months

◎ **Every twelve months**

Other schedule

Specify the other schedule:

---

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

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

◎ **The qualifications are different.**

Specify the qualifications:

The DOH/DDD Case Management Unit supervisors perform reevaluations. The case management supervisor is an individual who has at least one year of experience working directly with persons with intellectual disability or other developmental disability and who has graduated from an accredited university or is licensed/certified in a field related to developmental disabilities.

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

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

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

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

Evaluations and reevaluations are maintained in the participant's chart. The participant's original chart containing the evaluation/re-evaluation records is maintained in the assigned/respective case management unit.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of LOC evaluations completed for DDD participants applying for the Waiver N: # of LOC evaluations completed for individuals applying for the waiver D: Total # of all individuals applying for the waiver

Data Source (Select one):
Other
If 'Other' is selected, specify:
Database - DHS 1150C

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of initial LOC evaluations confirmed by the qualified DOH/DDD staff member N: # of initial LOC evaluations confirmed by the qualified DOH/DDD staff member D: Total # of initial LOC evaluations reviewed by the qualified DOH/DDD staff member

Data Source (Select one):
Other
If 'Other' is selected, specify:
Initial record review

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

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◎ **No**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

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

Prior to admission into the waiver, the DOH/DDD case manager reviews the applicant's service needs and options under the I/DD Waiver program. The applicant and legal guardian (if applicable) are informed of the choice to receive services through the waiver as an alternative to institutional placement. This is documented on the "Service Authorization Form".

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

Signed copies of the Service Authorization Form are maintained in the participant's chart. The participant's original chart containing the evaluation/re-evaluation records is maintained in the assigned/respective case management unit.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
DOH/DDD provides oral interpreters to individuals with limited English proficiency, sign language services and TTY/TDD services. These services are provided at no cost to the individual. There are a number of state case managers who are multi-lingual. DOH/DDD may use technology to communicate with those who do not use speech as their primary means of communication. DOH/DDD also produces information in alternate formats as requested. The DOH/DDD offers LEP services in accordance with Act 290, later codified in sections 371-31 to -37, Hawaii Revised Statutes, to ensure that LEP individuals have equal, meaningful access to state-funded services in Hawaii. This law applies to state agencies and covered entities that receive state-funding and provide services to the public. It requires state agencies and covered entities to establish a language access plan; and take reasonable steps to ensure they provide meaningful access to limited English Proficient persons. By statute (Chapter 321C) the DOH Office of Language addresses the language access needs of limited English proficient persons and ensures meaningful access to services, programs, and activities offered by the the DOH.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health (ADH)		
Statutory Service	Discovery & Career Planning (DCP)		

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health (ADH)

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:

Services generally furnished as specified in the Individualized Service Plan (ISP), in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. The desired outcomes include measurable improvements in individual independence, increased participation in the community and other

skill building that leads to increased community integration. Progress towards the participant's independence, community integration and skill development goals will be assessed and reviewed regularly to evaluate the measurable gains being made toward the goals. The participant's ISP may include a mix of Adult Day Health, Discovery & Career Planning, and Individual Employment Supports.

Individuals participate in structured age-relevant activities in a variety of settings other than their private residence.

Activities include training in activities of daily living (ADLs); instrumental activities of daily living (IADLs); communication; social skills and interpersonal relationships; choice making; problem-solving; teaching responsibility and teamwork; mobility training to develop skills necessary to use public transportation for community integration; and other areas of training identified in the ISP. Older participants of retirement age (age 60 and older unless specified in the ISP with justification for someone younger than that age) who no longer want to work may receive retirement supports to assist them in meaningful retirement activities in their community, including altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior related activities in their communities.

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

Any newly approved ADH providers during this waiver renewal period must be in full compliance with the CMS HCBS Settings Final Rule and be able to demonstrate the provision of services in fully integrated community settings. For settings that were operating prior to March 2014, the setting must be in compliance or working toward compliance as part of the My Choice My Way state transition plan.

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

ADH does not duplicate services provided as Discovery and Career Planning, Individual Employment Supports.

ADH excludes:

1) any time spent by the participant working for pay, including contracts, enclaves, groups or individual employment, regardless of the wage paid; and

2) supporting participants who independently perform activities that benefit the provider or its staff, i.e., independently doing services that would otherwise require the provider or its staff to pay for that service, such as landscaping, yard work, painting and housecleaning. This does not include routine chores and activities that participants engage in to maintain their common areas, practice responsibility and teamwork.

Personal care/assistance may be a component part of ADH services as necessary to meet the needs of a participant but may not comprise the entirety of the service.

ADH services may not be provided at the same time (same hour) as another face-to-face service, such as PAB, Discovery & Career Planning, Supported Employment (Individual with the exception of job development that may not be face-to-face with the participant, discussions with the employer or other supported employment-related activities where the participant is not present), and Respite.

Services will not duplicate services available to an participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health (ADH)

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):
Discovery & Career Planning (DCP)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*
Discovery & Career Planning (DCP) combines elements of traditional prevocational services with career planning in order to provide supports that are ongoing throughout the participant's work career. Discovery and Career Planning is based on the belief that all individuals with intellectual and developmental disabilities can work when given the opportunity, training, and supports that build on an individual's strengths, abilities and interests. This service is designed to assist participants to: 1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in integrated community employment; 2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills and abilities.. The outcome of DCP services is to complete or revise a career plan and develop the knowledge and skills needed to get a job in a competitive, integrated employment or be self-employed. Services are time-limited and shall increase individual independence and reduce level of service need. The participant's Individualized Service Plan (ISP) will include employment-related goals and the DCP activities are designed to support the employment goals.

Participation in DCP is not a pre-requisite for receiving Individual Employment Supports. The participant's ISP may include a mix of Adult Day Health, and Individual Employment Supports. When used as a wrap-around support for participants who work part-time, DCP must be coordinated with any Individual Employment Services or any other non-residential supports the participant is receiving to reinforce participation in competitive integrated employment as a priority life activity.

Personal care/assistance may be a component of DCP services, but does not comprise the entirety of the service.

Discovery and Career Planning services are time-limited activities that include the following:
1) exploring employment goals and interest to identify a career direction;
2) community-based formal or informal situational assessments;
3) task analysis activities;
4) mobility training to be able to use fixed route and/or paratransit public transportation as independently as possible;
5) skills training/ mentoring, work trials, apprenticeships, internships, and volunteer experiences;
6) training in communication with supervisors, co-workers and customers; generally accepted workplace conduct and attire; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and other skills as identified through the person-centered planning process;
7) broad career exploration and self-discovery resulting in targeted employment opportunities including activities such as job shadowing, information interviews and other integrated worksite based opportunities;
8) interviewing, video resumes and other job-seeking activities;
9) transitioning the participant into employment supports for individualized competitive integrated employment or self-employment from: a) volunteer work, apprenticeships, internships or work trials ; b) from a job that pays less than minimum wage; and c) from a more segregated setting or group employment situation;
10) financial literacy, money management, and budgeting; and
11) when assisting a participant who is already employed, activities to support the participant in explore other careers or opportunities.

Participants receiving DCP may be compensated in accordance with applicable Federal laws and regulations and the provision of DCP is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community.

Transportation to and from activities will be provided or arranged by the provider and included in the rate paid for the service. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the participant with priority given to the use of public transportation when appropriate.

Any newly approved Discovery & Career Planning providers during the waiver renewal period must be in full compliance with the CMS HCBS Settings Final Rule and be able to demonstrate the provision of services in fully integrated community settings. For settings that were operating prior to March 2014 as Prevocational Service providers, the setting must be in compliance or working toward compliance as part of the My Choice My Way state transition plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Discovery & Career Planning (DCP) services are limited to a maximum of 24 months of cumulative DCP with an expectation that the participant is working at the end of this period in a competitive integrated job or is self-employed. An extension of the authorization may be made for a second 24-month interval if the participant lost his or her job or has experienced a major gap

in employment due to health or other issues.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Discovery & Career Planning (DCP)

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Supported Employment
Alternate Service Title (if any):

Individual Employment Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*
Individual Employment Supports are based on the belief that all individuals with intellectual and developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain access to and maintain employment in the community, but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. Individual Employment Supports are designed to maximize the participant's skills, talents, abilities and interests. The goal of Individual Employment Supports is employment in a competitive integrated work setting. This is defined as a work place in the community or self-employed, where the participant receives at least minimum wage or the prevailing rate for that work, where the majority of individuals do not have disabilities, and which provides opportunities to interact with non-disabled individuals to the same extent that individuals employed in comparable positions would interact. Services may be ongoing based on the support needs of the participant and shall increase individual independence and reduce level of service need.

Individual Employment Supports are provided in accordance with the participant's Individualized Service Plan (ISP) and developed through a detailed person-centered planning process, which includes annual assessment of employment goals. The participant's ISP may include a combination of Adult Day Health-Traditional, Discovery & Career Planning, and Supported Employment.

Individual Employment Supports are activities needed to obtain and maintain an individual job in competitive or customized employment or self-employment, including home-based self-employment and may include:
1) on-going job coaching services to include on-the-job work skills training and systematic instruction required to perform the job with fading of supports as the participant becomes more confident and competent in the job to the extent possible;
2) person-centered employment planning;
3) job development, carving, or customization;
4) negotiations with prospective employers;
5) assistance for self-employment, including 1) assist in identifying potential business opportunities; b) assist in the development of a business plan, including potential sources of business financing and other assistance needed to develop and launch a business; c) identification of supports needed in order for the participant to operate the business; and d) ongoing assistance, counseling and guidance once the business has been launched;
5) worksite visits as needed by the individual or employer to assess for new needs and to proactively support the participant to address issues that arise (typically at the worksite unless the individual requests visits outside the worksite or worksite visits are deemed too disruptive by the employer);
6) ongoing evaluation of the individual's job performance except for supervisory activities rendered as a normal part of the business setting; training related to acclimating to or acceptance in the workplace environment, such as effective communication with co-workers and supervisors and when and where to take breaks and lunch;
7) individualized problem-solving/advising with the participant about issues that could affect maintaining employment;
8) training in skills to communicate disability-related work support and accommodation needs;
9) assessing the need for basic job aids, facilitating referral through the participant's DOH/DDD case manager for assistive technology assessment and acquisition of assistive technology from Division of Vocational Rehabilitation;

10) facilitating referral through the DOH/DDD case manager to a Discovery & Career Planning provider for financial literacy, money management and budgeting;
11) providing information and training, as appropriate, for employers related to disability awareness, use of tax credits and other incentives, individual disability-specific training, and use of basic job aids and accommodations (may or may not be delivered with the participant present); and
12) training in arranging and using transportation, such as fixed route public transportation or paratransit services to get to and from the participant's place of employment;
13) career advancement services.

When Individual Employment Supports are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by the participant receiving waiver services as a result of his or her disabilities.

Personal care/assistance may be a component of Individual Employment Supports, but does not comprise the entirety of the service. If ongoing personal assistance is needed, the DOH/DDD case manager may authorize employment aid services at the workplace.

Transportation to and from the supported employment activities shall be arranged by the provider and participant and is included in the rate for this service.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those programs beyond any program limitations.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are limited to a maximum of eight (8) hours per day, 40 hours per week.

Individual Employment Supports exclude:
1) supporting the participant to perform work that benefits the waiver provider, regardless of wage paid, including paid employment in an enterprise owned by the provider of Individual Employment Supports or a relative of that provider;
2) paying incentives, subsidies or for unrelated vocational training expenses such as the following:
- incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment arrangement;
- payments that are passed through to participants receiving Individual Employment Supports;
- payments for training that is not directly related to the participant's Individual Employment Supports;
3) paying expenses with starting up or operating a business; and
4) continuing the service for the sole purpose of providing transportation to and from the place of employment once the participant no longer needs job coaching
5) paying for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Individual Employment Supports (with the exception of job development, negotiations with prospective employers or meetings and phone calls where the participant may not be present, such as discussions with the supervisor or family) may not be provided at the same time (same hour) as another face-to-face service, such as PAB, Discovery & Career Planning, or Respite.

Services will not duplicate or replace services available to an participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Employment Supports

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st of month of service for initial evaluation and every succeeding 12th month thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Habilitation
Alternate Service Title (if any):
Personal Assistance/Habilitation (PAB)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
A range of assistance or training to enable program participants to assist with the acquisition, retention or improvement in skills related to living in the community. These supports may include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, social and leisure skill development. Services may also include training to increase independence as well as developing natural supports and relationships. This may take the form of hands-on assistance (actually performing a task for the person), training, or multi-step instructional cueing, as a part of a plan to prompt the participant to perform a task.

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

Personal assistance/habilitation (PAB) services may be provided on an episodic or on a continuing basis.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Out-of-State PAB services cannot exceed 14 calendar days in a fiscal year (July 1 through June 30) for one staff to accompany the participant. An exception process is in place for emergency situations that could arise during travel that would require additional authorization of hours. Out-of-state PAB is approved for the same amount of hours as the current authorization.

For participants under age 21, PAB may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration (QI) health plans.

PAB services may not be delivered during the school day or educational hours as defined for that student through the Individualized Education Plan (IEP), such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the waiver will not provide PAB services during the times when the participant would otherwise be attending school.

PAB shall not be provided at the same time (in the same hour of the day) as Respite services.
Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Assistance/Habilitation (PAB)

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistance/Habilitation (PAB)

Provider Category:
Individual
Provider Type:
Consumer Directed Direct Support Worker (DSW)
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Consumer directed – must be at least 18 years of age, complete criminal history check , meet qualifications in job description - trained and supervised by the participant/designated representative
Verification of Provider Qualifications
Entity Responsible for Verification:
Employer/Designated Representative
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service
Service:
Residential Habilitation
Alternate Service Title (if any):
Residential Habilitation (ResHab)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

◎ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Residential habilitation are individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living and instrumental activities of daily living, community inclusion, transportation, and social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation does not include general care and protective oversight and supervision which are required under the home's license or certification requirements. Residential Habilitation is a service, not a setting.

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

Residential habilitation may be provided in licensed and/or certified homes or in the community but does not duplicate services furnished to the participant as other types of habilitation; participants can receive Residential Habilitation on the same day as non-residential services.

Transportation between the participant's residence and activities in the community is provided as a component of residential habilitation services and the cost of transportation is included in the rate paid.

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

There may be rare occasions when a participant living in a residential habilitation setting requires more staffing than the home's caregiver would provide as part of the cost of this service. These are typically due to complex behavioral or physical care needs are short term. When deemed necessary, DOH/DDD can authorize PAB staff to enhance the supports rendered by the residential habilitation caregiver for a period of time each day. When PAB is provided in the ResHab setting, this is a distinct and separate service that can be billed in 15-minute increments during the hours of ResHab.

Provider-owned or –leased settings must be compliant with the Americans with Disability (ADA) requirements. These settings must also provide a home-like environment. Any newly approved providers (settings that begin providing services on and after July 1, 2016) must be in full compliance with the CMS HCBS Settings Final Rule. For settings that were operating prior to

March 2014, the setting must be in compliance or working toward compliance as part of the My Choice My Way state transition plan.

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

Discovery & Career Planning (DCP) services are limited to a maximum of 24 months of cumulative DCP with an expectation that the participant is working at the end of this period in a competitive integrated job or is self-employed. An extension of the authorization may be made for a second 24-month interval if the participant lost his or her job or has experienced a major gap in employment due to health or other issues.

DCP are not intended to teach the participant task specific skills to perform a particular job. This is provided under other waiver services: Individual Employment Supports.

DCP services may not be provided at the same time (same hour) as another face-to-face service, such as PAB, Adult Day Health, Individual (with the exception of job development & customization that may not be face-to-face with the participant or contacts with the employer or others where the participant may not be present) or Respite.

Services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

DCP excludes:
1) providing vocational services where participants are supervised for the primary purpose of producing goods or performing services, including services provided in sheltered workshops and contract work at less than minimum wage;
2) payments that are passed through to users of DCP, including payments of wages or stipends for internships or work experience;
3) paying employers incentives to encourage or subsidize the employer's participation in internships or apprenticeships;
4) supporting participants to volunteer at for-profit organizations or businesses or to independently perform services without pay ("volunteering") that benefit the waiver service provider or its staff and which would otherwise require the provider or staff to pay to have that service completed, such as landscaping, painting, or housecleaning;
5) supporting any activities that involve payment of sub-minimum wage; and
6) offering services in settings that do not meet the criteria included in the service definition.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation (ResHab)

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:
DOH/DDD

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Respite services are only provided to participants living in family homes and are furnished on a short-term basis to provide relief to those persons who normally provide uncompensated care for the participant for at least a portion of the day. Respite may be provided in the participant's own home, the private residence of a respite care worker, DD Domiciliary Home, DD

Adult Foster Home, Adult Residential Care Home, or Expanded Adult Residential Care Home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Multiple episodes of respite may occur during the year. However, any episode of respite is limited to 14 consecutive days. The DOH/DDD will perform further authorization on a case-by-case basis.

Federal financial participation is not claimed for the cost of room and board in any of these settings. Respite is not available in long-term care facilities.

Respite cannot be used during times when the person providing care is being paid to deliver another waiver service, such as PAB or CLS. It is limited to providing for relief during times when the person is not being paid to provide care to the participant.

Respite services provided on an hourly basis are not delivered during the same time (same hour) that the following face-to-face services are delivered: PAB, ADH, Discovery & Career Planning, Individual or Group Employment Supports, or Community Learning Services.

A guardian or legally responsible adult (parent of a minor aged 17 and younger or spouse of the participant) cannot be the Respite worker.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Consumer Directed Direct Support Worker (DSW)
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Consumer directed – at least 18 years of age, complete criminal history check, meet qualifications in job description - trained and supervised by the participant/designated representative
Verification of Provider Qualifications
Entity Responsible for Verification:
Employer/Designated Representative
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid Provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Skilled Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Skilled nursing services include services listed in the ISP that are within the scope of the State's Nurse Practice Act and require the education, assessment, judgment and intervention of a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN. The RN and LPN are licensed to practice in the state of Hawaii. Skilled Nursing Services include the provision of nursing assessment, treatments and observation consistent with physician's orders and in accordance with the written health care plan in the participant's record. The nurse provides detailed notes of interventions, judgments and assessments and makes documentation available at the frequency specified in the ISP for the DOH/DDD case manager and upon request, review by DOH/DDD.

Skilled Nursing services are provided on an intermittent, part-time and time-limited basis. "Intermittent and part-time" is defined as occurring at irregular intervals, sporadic, and not continuous.

Personal care/assistance may be provided when incidental to the delivery of Skilled Nursing as necessary to meet the needs of a participant but may not comprise the entirety of the service.

The DOH/DDD actively review participants when skilled nursing hours reach certain thresholds that would indicate the service is not intermittent, time-limited and/or part-time. DOH/DDD will also assess whether these participants still meet criteria for and can benefit from the waiver or whether intense medical needs requiring more continuous nursing care make them more appropriate for QUEST Integration (QI) services from the health plans.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Skilled Nursing Services under the waiver may not replace the services available under the State Plan. Medically necessary skilled nursing services that are covered under the State Plan are provided by the QUEST Integration (QI) health plans. For participants under age 21, Skilled Nursing Services may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration health plans.

Skilled Nursing Services shall not be used in place of PAB services where the participant's needs could be met with a trained PAB worker performing nurse-delegated tasks but the agency has not hired and trained a worker. An exception may be requested through the DOH/DDD in an emergency situation for short-term coverage while the agency hires and trains a PAB worker.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

☐ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License *(specify)*:
Licensed Registered Nurse per Chapter 457, Hawaii Revised Statutes

Licensed Practical Nurse per Chapter 457, Hawaii Revised Statutes

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State. Each agency must follow the Hawaii State Administrative Rules regarding the Hawaii Nurse Practice Act.

Verification of Provider Qualifications

Entity Responsible for Verification:
DOH/DDD

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities of participants. The assistive technology must be for the use of the participant and necessary as specified in the ISP to assist the participant in achieving identified measurable goals, has high potential to increase autonomy and reduce the need for physical assistance, and is the most cost-effective option. A functional assessment must be completed by a clinician within the scope of his or her license that evaluates the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant.

Assistive technology services include:
1) assisting the participant to select, purchase, lease, or acquire assistive technology devices for participants;
2) designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices; and
3) coordinating with the DOH/DDD case manager to obtain any necessary therapies, interventions, or services with assistive technology devices.

This service includes assessment, training or technical assistance to the participant, or where appropriate, the family members, guardians (if applicable), authorized representatives of the participant or other individuals who provide services to, employ or are otherwise substantially involved with the participant.

Assistive technology services include:
1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;

4. Coordination and use of necessary therapies, interventions, or services with assistive technology devices such as therapies, interventions, or services associated with other services in the service plan;

5. Training or technical assistance for the participant, or where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

6. Training or technical assistance for professional or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Commercially-available technology such as tablets and software applications are available only for the purposes of communication if not eligible under the QUEST Integration health plan or as a job aid for employment if not eligible under the Division of Vocational Rehabilitation.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education act (20 U.S.C. 1401 et seq.) or covered under EPSDT or the State Plan through the QUEST Integration health plans or covered by other insurance. If the device would have been covered but the plan rules were not followed, the device shall not be purchased using waiver funds.

Replacement of assistive technology may be made when an assessment determines that it is more cost-effective to replace rather than repair the item and shall not occur more frequently than once a year for low-technology solutions or once every two years for customized, adapted or higher-technology devices.

The purchase, training and upkeep of service animals are excluded. Internet service, laptops, personal computers and cell phones are excluded.

Payment for services is based on compliance with billing protocols and completed supporting documentation as required by the Medicaid Waiver Standards.

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

☐ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
Prior to and after service delivery OR 1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Vendor
Provider Qualifications
License *(specify)*:
State of Hawaii Department of Commerce & Consumer Affairs, if applicable State General Excise Tax license
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
Prior to and after service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Chore

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture, in order to provide safe access and egress as well as more routine or regular services such as the performance of general household tasks, e.g., meal preparation and routine household care for the participant only. These services are available to participants living independently who need Chore services and are without natural (non-paid) supports or who are living with family but the natural supports are physically unable to perform the chores. Documentation must indicate that no other party is capable of and responsible for providing chore services, including the participant, anyone else financially providing for him/her, and another relative, caregiver, landlord, community/volunteer agency, or third party payer.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Chore services may not be authorized for participants live who independently or with family where either the participant or

natural supports are able to perform this service.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:
Individual
Provider Type:
Consumer Directed Direct Support Worker (DSW)
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Consumer directed – is 18 years of age or older, completes criminal history check and meets qualifications in job description - trained and supervised by the participant/designated representative
Verification of Provider Qualifications
Entity Responsible for Verification:
Employer/Designated Representative
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider Agency, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:
DOH/DDD

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

◉ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Those physical adaptations permanently installed to the participant's home, required by the participant's ISP , that are necessary to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, environmental control devices that replace the need for physical assistance and increase the

participant's ability to live independently, such as automatic door openers, or the installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies that are necessary for the welfare of the participant and directly related to the participant's developmental disability.

Adaptations must be of direct medical or remedial benefit and not be considered experimental.

"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement. "Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal.

As part of this service, a functional assessment must be completed by a clinician within the scope of his or her license that evaluates the need for and functional impact of the provision of appropriate adaptations to the home. Once the adaptation has been completed, the clinician will provide training in the use of the adaptation.

Adaptations are for homes owned by the participant and/or legal guardian (if applicable) or family with documentation provided to demonstrate ownership. Adaptations may be completed on a rental property where the property owner has agreed in writing to the adaptation and will not require that the property be restored to the previous floorplan or condition.

Adaptations must be ordered by a physician or other health provider with prescriptive authority under Hawaii law. The order must be dated within one year of the request.

All adaptations shall be made utilizing the most cost effective materials and supplies. The environmental modification must incorporate reasonable and necessary construction standards.

The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, water/sewer, foundation, smoke detector systems, roof, free of pest damage) must be in compliance with any applicable local codes. This service shall exclude costs for improvements exclusively required to meet local building codes.

The process is the same for obtaining any environmental accessibility adaptation, whether for a first modification or if requesting an exception because of extenuating circumstances that could not be anticipated at the time the initial environmental accessibility adaptation was completed. The process begins with the person-centered planning discussion and recommendations in the ISP. A referral is made to obtain an assessment by a licensed clinician, generally an occupational therapist or physical therapist. Once the assessment and recommendations are completed, it is reviewed by a team of DOH/DDD staff. The review determines if all the necessary information has been provided for justification of medical need or if additional information is required to develop the scope of work. The scope is posted on the State of Hawaii procurement website and offers or submit bids. The bids are reviewed and an award is made. Once the work is completed, the clinician that completed the initial assessment visits the home, trains the family and participant, and signs off that the adaptation meets the individual's needs. The DOH/DDD team works closely with the case manager, unit supervisor and section supervisor to facilitate the process. If the requested adaptation does not meet medical need or waiver requirements for authorization through the waiver, the participant or legal representative, if applicable, is given a Notice of Action stating the reason for the action taken and may appeal that decision.

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

Limit of $40,000 per request which includes a maximum of $35,000 for the modification and a maximum of $5,000 for the engineering or architectural drawings and permits required by the city or county where the home is located.

Requests for modifications are limited to once in the life expectancy of the modification as follows:
Grab bars – 5 years
Environmental Control Devices (automatic door opener) – 5 years
Exterior ramp – 7 years
Bathroom modification – 15 years
Widen doors and hallways – 15 years
Other modifications – determined on a case-by-case basis

A participant may request more than one modification within a 5 calendar year period but the requests must be medically necessary to address different needs, such as a ramp for access to the building and a roll-in shower for bathing.

Exceptions may be made for health and safety of the participant, e.g., participant condition changes and needs a modification in order to remain in the community or the participant must move from a rented setting. Participants are always afforded the ability to request that DOH/DDD review the participant's situation if a modification is needed prior to the life expectancy of the modification period.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant [carpeting, roof repair, sidewalks, driveways, garages, hot tubs, whirlpool tubs, swimming pools, landscaping, pest control and general home repairs and maintenance]. Cosmetic improvements are excluded. Egress is limited to one exterior door. Additional square footage is excluded.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Independent Contractor
Provider Qualifications
License *(specify)*:
State of Hawaii Department of Commerce & Consumer Affairs
State General Excise Tax License
Valid General Contractor's license in the State of Hawaii
Certificate *(specify)*:

Other Standard *(specify)*:
Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
Prior to, during and after service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Service offered to enable participants to gain access to waiver services and other (non-waiver) community services, activities and resources, as specified in the Individual Service Plan (ISP). Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized. The service may be used by a participant who lives in a rural or other area where public transportation is limited or non-existent or if the participant requires door-to-door transportation because he/she is unable to reasonably access the bus-stop or other public pick-up location. This service may be consumer-directed.

Non-Medical Transportation services under the waiver are offered in accordance with the participant's ISP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The most cost-effective mode of transportation will be authorized.

This service shall not be used to provide medical transportation required under 42 CFR §431.53 and transportation services under the State plan delivered through the QUEST Integration health plans. Non-Medical Transportation Services may not duplicate transportation that is included within another waiver service or to transport the participant to a setting that is the responsibility of another agency, such as the Department of Education.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

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

Specify whether the service may be provided by *(check each that applies)*:
☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:
Valid Driver's license
P.U.C. license as appropriate
Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Each agency must follow P.U.C. standards, as applicable.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual
Provider Type:
Consumer Directed Direct Support Worker (DSW)
Provider Qualifications
License *(specify)*:
Valid Hawaii Driver's License
Certificate *(specify)*:

Other Standard *(specify)*:
Consumer directed – is 18 years of age or older, completes criminal history check and meets qualifications in job description - trained and supervised by the participant/designated representative
Verification of Provider Qualifications
Entity Responsible for Verification:
Employer/Designated Representative
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:

PERS is a system that enables waiver participants to secure help in an emergency and maintain safety in the community. As part of the system, a participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. The response center may also provide daily reminder calls to participants or respond to other environmentally triggered alarms, e.g., motion detectors, etc., in the household. Service includes a one-time installation fee for new systems and up to 12 months per year for on-going monitoring of the system.

Assessment of the need for this service, as well as training in the use of the PERS, is included in the waiver service.

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

This service is available for participants living in their own home or family home.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

◎ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

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

There must be documented evidence that the item is the most cost-effective alternative to meet the participant's need. All items must be ordered on a prescription. An order is valid one year from the date it was signed.

All items shall meet applicable standards of manufacture, design and installation.

Nutritional diet supplements, such as Ensure and Pediasure, are only covered by the waiver if the participant is able to eat by mouth (no feeding tube) and is at risk for weight loss that will adversely impact the participant's health. Prior to authorization, the plan includes a request from a medical provider and measurable weight goals and a follow-up plan.

Additional diapers, pads and gloves over the amount covered by the State Plan may be covered by the waiver only on a temporary or intermittent basis. Temporary is defined as a period of three months or less. Intermittent is defined as occurring at irregular intervals, sporadic and not continuous.

Assessment of the need for this service, as well as training in the use of Specialized Medical Equipment and Supplies, is included in the waiver service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized Medical Equipment and Supplies under the waiver may not replace the medical equipment and supplies covered by other insurances or under the State Plan through the QI health plans, including EPSDT medically necessary equipment and supplies for waiver participants under age 21. All applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies must be followed. This service may not be used to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using network providers that participate with that program and adhering to prior authorization requirements of that program..

Specialized Medical Equipment and Supplies exclude those items that are not of direct medical or remedial benefit to the participant or are considered to be experimental.

"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or supply that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement. "Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal.

Eye glasses, hearing aids, and dentures are not covered.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

☐ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Agency	Medical Supply Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:
State of Hawaii Department of Commerce & Consumer Affairs, if applicable
Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
Prior to, during and after the service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Medical Supply Company
Provider Qualifications
License *(specify)*:
State of Hawaii Department of Commerce & Consumer Affairs, if applicable
State General Excise Tax license
Certificate *(specify)*:

Other Standard *(specify)*:
Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
Prior to, during and after the service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Training and Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:

Training and consultation services assist unpaid caregivers, paid service supervisors and/or paid support staff in implementing the goals and outcomes developed from the person-centered planning process and included in the Individualized Service Plan (ISP). The goals and outcomes are necessary to improve the participant's independence and inclusion in their community. Consultation activities are provided by professionals in psychology, nutrition, occupational therapy, physical therapy, speech and language pathology, psychiatry, and behavior analysis. The service may include evaluation and assessment; the development of recommendations for the goals and outcomes; training and technical assistance to implement the goals and outcomes; and monitoring of the participant, caregivers and providers in the implementation of the goals and outcomes. This service may be delivered in the participant's home or in the community as described in the ISP.

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

Training and Consultation is time limited, intermittent, and consultative. Training and consultation is not intended to provide direct services beyond the time required for the face-to-face evaluation and assessment, training, observing/monitoring the implementation of the goals and revising/updating outcomes as appropriate.

For participants under age 21, Training and Consultation may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration health plans. This service does not supplant any service that is the responsibility of the Medicaid State Plan under the QUEST Integration health plans, another agency or other insurance.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Consultation

Provider Category:
Individual
Provider Type:
Independent contractor
Provider Qualifications
License *(specify)*:
State of Hawaii Department of Commerce & Consumer Affairs
State General Excise Tax License
All professionals meet appropriate licensing requirements
Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each provider must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.
Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
Prior to and after service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Consultation

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider, i.e., agency with Medicaid Provider agreement
Provider Qualifications
License *(specify)*:
All professionals meet appropriate licensing requirements
Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:
DOH/DDD

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Vehicular Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:
Adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified in the ISP as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

The approved amount is based on modifications to a full-sized van or standard size automobile.

Assessment of the need for this service, as well as training in the use of the Vehicular Modification, is included in the waiver service.

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

Modifications are limited to $25,000 per request, one request every 7 years, including if received under previous waiver period.

The following are specifically excluded:
1) adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
2) purchase or lease of a vehicle;
3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification;
4) modifications to a minivan to lower the floor and rebuild the frame to accommodate a lift; and
5) modifications that are for the convenience of the caregiver/driver and are not used by the participant, such as automatic door openers and automatic starters.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicular Modifications

Provider Category:
Individual

Provider Type:
Vendor

Provider Qualifications

License *(specify)*:
State of Hawaii Department of Consumer Affairs, if applicable
State General Excise Tax license

Certificate *(specify)*:

Other Standard *(specify)*:
Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:
DOH/DDD

Frequency of Verification:
Prior to and completion of service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Waiver Emergency Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:

Waiver emergency services (outreach) shall be defined as the initial call requesting outreach and the 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. The outreach service must be face-to-face with the participant for at least a portion of the visit.

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

This benefit is primarily focused on services for adults.

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

The DOH/DDD is actively involved in the review of participants when crisis shelter hours reach certain thresholds.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Waiver Emergency Services

Provider Category:
Agency
Provider Type:
DOH/DDD Waiver Provider; i.e, agency with Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Verification of Provider Qualifications
Entity Responsible for Verification:
DOH/DDD
Frequency of Verification:
1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

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

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

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

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

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

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

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

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

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

State Department of Health, Developmental Disabilities Division Case Managers

Appendix C: Participant Services

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

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

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

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

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

a) all service supervisors (SS) and direct support workers (DSW) employed through an agency or individual providers (independent contractors)
b) state and federal
c) Provider agencies must obtain background checks from the Criminal History Data Center (CHDC) which is part of the State's Department of the Attorney General. The background check must be stamped "certified". The CHDC performs a screen match of the providers' fingerprints and name against both the FBI and State of Hawaii database for criminal activity. The provider must obtain the CHDC check before the employee is allowed to provide services to DD/ID waiver participants or within five (5) calendar days of initial hire and then within 12 months of initial CHDC check. The provider performs the name checks bi-annually thereafter.

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

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

No. The State does not conduct abuse registry screening.

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

a) Fieldprint, an entity contracted by several agencies in the State of Hawaii Department of Human Services
b) all service supervisors (SS) and direct support workers (DSW) employed through an agency
c) Provider agencies complete Adult Protective Services (APS)/Child Protective Services (CPS) background checks and fingerprinting as specified in the provider agreements.

DOH/DDD staff monitors and checks agency records annually to ensure that mandatory screenings have been conducted. DOH/DDD submits quarterly reports to DHS/MQD for review.

Appendix C: Participant Services

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

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

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	

Adult Residential Care Home
Develpmental Disabilities Domiciliary Home
Adult Foster Home
Special Treatment Facility
Expanded Adult Residential Care Home (E-ARCH)
Special Treatment Facility/Transitional Living Program

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

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

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	☐
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☐
Personal Emergency Response System (PERS)	☐
Respite	☐
Residential Habilitation (ResHab)	☐
Assistive Technology	☐
Individual Employment Supports	☐
Training and Consultation	☐
Non-Medical Transportation	☐

Chore	☐
Skilled Nursing	☐
Specialized Medical Equipment and Supplies	☐
Adult Day Health (ADH)	☐
Vehicular Modifications	☐

Facility Capacity Limit:

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

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Develpmental Disabilities Domiciliary Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	☐
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☑

Personal Emergency Response System (PERS)	☐
Respite	☑
Residential Habilitation (ResHab)	☑
Assistive Technology	☑
Individual Employment Supports	☐
Training and Consultation	☑
Non-Medical Transportation	☐
Chore	☐
Skilled Nursing	☐
Specialized Medical Equipment and Supplies	☑
Adult Day Health (ADH)	☐
Vehicular Modifications	☐

Facility Capacity Limit:

5 participants

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	☑
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☑
Personal Emergency Response System (PERS)	☐
Respite	☑
Residential Habilitation (ResHab)	☑
Assistive Technology	☑
Individual Employment Supports	☐
Training and Consultation	☑
Non-Medical Transportation	☐
Chore	☐
Skilled Nursing	☑
Specialized Medical Equipment and Supplies	☑
Adult Day Health (ADH)	☐
Vehicular Modifications	☐

Facility Capacity Limit:

2 participants

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Special Treatment Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	☑
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☑
Personal Emergency Response System (PERS)	☐
Respite	☐
Residential Habilitation (ResHab)	☐
Assistive Technology	☑
Individual Employment Supports	☐
Training and Consultation	☐
Non-Medical Transportation	☐
Chore	☐
Skilled Nursing	☐
Specialized Medical Equipment and Supplies	☑
Adult Day Health (ADH)	☐
Vehicular Modifications	☐

Facility Capacity Limit:

1-8 participants

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑

Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Expanded Adult Residential Care Home (E-ARCH)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	☑
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☑
Personal Emergency Response System (PERS)	☐
Respite	☑
Residential Habilitation (ResHab)	☑
Assistive Technology	☑
Individual Employment Supports	☐
Training and Consultation	☑
Non-Medical Transportation	☐
Chore	☐
Skilled Nursing	☑
Specialized Medical Equipment and Supplies	☑
Adult Day Health (ADH)	☐
Vehicular Modifications	☐

Facility Capacity Limit:

2 E- ARCH level participants

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

Scope of State Facility Standards

Standard	Topic Addressed

Admission policies	☑
Physical environment	☐
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Special Treatment Facility/Transitional Living Program

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	☑
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☑
Personal Emergency Response System (PERS)	☐
Respite	☐
Residential Habilitation (ResHab)	☐
Assistive Technology	☑
Individual Employment Supports	☐
Training and Consultation	☐
Non-Medical Transportation	☐
Chore	☐
Skilled Nursing	☐
Specialized Medical Equipment and Supplies	☑
Adult Day Health (ADH)	☐

Vehicular Modifications	☐

Facility Capacity Limit:

1-5 participants

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

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

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

◎ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

The State does not make payment to relatives/legal guardians for furnishing waiver services.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

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

Parents and legal guardians (if applicable) of minor children are not paid to provide services.

Relatives or family members who may provide waiver services to minor participants are defined as natural or hanai (Hawaiian tradition of taking in and caring for an individual without going through formal adoption procedures) brother, sister, aunt, uncle, cousin, grandfather or grandmother.

Spouses of participants are not paid to provide services.

Relatives or family members who may provide waiver services to adult participants are defined as natural, adoptive, step, in-law, or hanai father, mother, brother, or sister, son or daughter, and grandfather or grandmother. Guidelines for authorizing waiver services which may be provided by a family member include:
1) the family member is unable to provide the service(s) without reimbursement; and
2) the family member is the most qualified provider; or
3) the family member is the only available provider of care.

Relatives/legal guardians employed through provider agencies or relatives employed through the consumer directed model are subject to the same monitoring and supervision requirements as non-relatives/non-legal guardians.

Under the consumer directed model, a legal guardian for a participant may not hire himself or herself to provide the services for which he or she serves as the designated representative.

Other policy.

Specify:

---

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

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

Applicants that are determined to not be qualified to enroll are required to wait six (6) months and receive provider training prior to re-submitting an application.

All providers may be authorized to deliver one or more waiver services based on their ability to meet provider qualifications.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of new direct support workers (DSWs) that passed the criminal history record and abuse registry checks prior to service delivery N: # of new DSWs that passed the criminal history record and abuse registry checks prior to service delivery D: Total # of new DSWs in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review of Hawaii's DD/ID Waiver Providers

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

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of new direct support workers (DSW) that passed the criminal history record and abuse registry checks prior to service delivery validated by DHS/MQD N: # of new direct support workers (DSW) that passed the criminal history record and abuse registry checks prior to service delivery validated by DHS/MQD D: Total # of new direct support workers (DSW) records reviewed by DHS/MQD

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider on-site reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review

	☒ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-annually

Performance Measure:
#/% of participant of records that meet State standards N: # of participant records that meet State standards D: Total # of applicable participant records in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review of Hawaii's DD/ID Waiver Providers

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of participant records that meet State standards and validated by DHS/MQD N: # of participant records that meet State standards and validated by DHS/MQD D: Total # of participant records reviewed by DHS/MQD

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider on-site reviews

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Validation record review

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of non-licensed/non-certified providers/consumer directed providers that meet waiver requirements. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record

		review
	☐ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of new direct support workers (DSWs) that completed the required training prior to service delivery N: # of new DSWs that completed the required training prior to service delivery D: Total # of new DSWs

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review of Hawaii's DD/ID Waiver Providers

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of new direct support workers (DSWs) that completed the required training prior to service delivery validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of non-licensed/non-certified providers/consumer directed providers that meet training requirements. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOH/DDD performs annual on-site reviews of licensed/certified providers to verify that providers meet waiver requirements. For non-licensed/non-certified consumer/consumer directed providers, DOH/DDD gathers information on compliance as part of their QA/QI Review for Case Management Services. If a provider is non-compliant with waiver requirements, e.g. agency personnel did not receive required training from the provider agency, DOH/DDD is responsible to ensure that the agency provides the training and to track and document this when completed. DOH/DDD in consultation with DHS/MQD may issue appropriate sanctions to the provider for the period of non-compliance e.g., recoupment of billed services, suspension of services, termination. Results of the on-site and record reviews are submitted to DHS quarterly. DHS/MQD accompanies DOH/DDD on a sample of on-site reviews.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-annually

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

◉ **No**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Requirements for in-state and out-of-state provision of services:

a) all waiver services, with the exception of Personal Assistance/Habilitation (PAB) and consumer-directed PAB (CD PAB), must be provided in-state only. PAB and CD PAB are the only services that can be provided out-of-state within the United States. No waiver services shall be provided out of the country;

b) based on historical utilization patterns, a typical request for vacation out-of-state is 10 to 14 days annually. The 14-day limit for out-of-state vacations has been in effect for a number of years. An exception process exists if an emergency situation were to arise during the participant's travel;
i) an updated ISP action plan identifying the travel out-of-state shall be completed and signed by the participant or guardian (if applicable), waiver provider, and DOH/DDD case manager. The participant or guardian has identified a back-up plan for assuring the PAB staff hours per week do not exceed what is assessed in the current ISP action plan. Except for unforeseeable emergency situations, the participant or guardian uses the back-up plan to ensure that the participant's needs can be met within the authorized days and hours;
ii) the participant's PAB worker accompanies the participant and provides the service. The DOH/DDD does not pay for any of the travel costs or accommodations for the participant and the PAB worker;

c) unless the DOH/DDD identifies situations that require changes to the limit, the DOH/DDD does not anticipate adjusting the limit;

d) for any emergency situation in order to safeguard the health and welfare of the participant, the DOH/DDD administration shall assess the need for an increase in PAB services on a case-by-case basis. Participants who may require medical treatment out-of-state shall be referred to the QUEST Integrated Medicaid Health Plans;

e) participants and their family or guardians (if applicable) are able to contact their case managers to explain unusual or unexpected situations that require authorization of out-of-state services. As noted in (d), services may be authorized above the limit by certain individuals within the organization; and

f) participants are notified that all services, except for PAB, must be provided in-state when they are accepted into the waiver program. The providers are aware of the requirement as it is written in the Medicaid Waiver Standards.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individualized Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
☑ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case managers must meet the qualifications of either social worker, human services professional, or registered professional nurse licensed to practice in the state.

Social Workers (SW) are those with a Master's in Social Work (MSW) or a Bachelor's in Social Work (BSW) from a program of study accredited by the Council on Social Work Education, or a doctorate degree in social work from a college or university accredited by the Western Association of Schools and Colleges, or a comparable regional accreditation body. A SW with a bachelor's degree must have minimally one (1) year of progressively responsible professional work experience in a social/human/health service type of setting.

Minimum qualification requirements for Human Service Professional (HSP) is graduation from an accredited four (4) year college or university with a bachelor's degree which included a minimum of 12 semester credit hours in courses such as counseling, criminal justice, human services, psychology, social work, social welfare, sociology or other behavioral sciences. The HSP must also have minimally 1.5 years of progressively responsible professional work experience in a social/human/health service type of setting.

SW and HSP workers are also trained in the DOH/DDD branch policies and procedures as related to service plan development.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◎ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) The person-centered planning process is driven by the participant who is the center of the planning process. Hawaii Revised Statutes (HRS) chapter 333F governing services for people with developmental disabilities and/or intellectual disabilities provides the statutory mandates for person-centered planning and self-determination. HRS § 333F-1 defines the individualized service plan (ISP) as the "written plan required by HRS § 333F-6 that is developed by the individual, with the input of family, friends, and other

persons identified by the individual as being important to the planning process." The person- centered process provides necessary information and support to the participant to ensure that the individual directs and facilitates the process to the maximum extent possible.

b) Participants receive information regarding person-centered planning in both written and oral formats. Family members receive "A Guide to Person-Centered Planning" brochure that includes self-determination principles.

A Case Management Branch (CMB) brochure outlines the supports and services funded by Department of Health, Developmental Disabilities Division (DOH/DDD). Participants also receive the "Home and Community Based Services (HCBS) for persons with developmental disabilities Medicaid Waiver Program" brochure, which provides information on eligibility and services offered under the HCBS waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The ISP is the written plan required by HRS § 333F-6. The DOH/DDD case manager assists the participant to develop the ISP, with the input of the circle of support, family, friends, and other persons chosen by the participant as being important to the planning process. The "circle of supports" may include parents, guardians (if applicable), siblings, friends, paid and unpaid supports, service provider(s) and the DHS Quest Integration (QI) Integration (I) service coordinator. An ISP is initiated after eligibility for services is determined by the DOH/DDD. An ISP is initiated after eligibility for services is determined by the DOH/DDD.The ISP is reviewed/updated prior to being admitted into the waiver, and annually thereafter.The actual ISP meeting shall occur at times and locations of convenience to the participant. Prior to the ISP meeting the DOH/DDD case manager contacts the participant and/or guardian to ask them about their available time and location preferences.

b) Assessment information is gathered by qualified DOH/DDD staff and the participant directly through interviews and direct observation. Information is also obtained from persons who know the participant well, such as family members, guardians (if applicable), friends, residential providers, service providers and health professionals.
Types of assessments used by the DOH/DDD case managers include:
i) a service planning assessment, e.g. the Inventory for Client and Agency Planning (ICAP) or the Supports Intensity Scale (SIS) conducted by qualified DOH/DDD staff identifies the participant's areas of support needs, relative strengths and challenges, as well as medical and/or behavioral concerns;
ii) prior to the ISP, the DOH/DDD case manager, identifies the participant's circle with the participant and/or guardian (if applicable) to include, other supporting agencies. The DOH/DDD case manager with the participant and /or guardian obtains information on the following sections of the ISP: person-centered planning preferences, This is Who I Am, How I communicate, What's Important and Meaningful to Me; and "My Information", which documents "My Health" (includes clinical and support needs, diagnosis/medical conditions, allergies, medications and health supports), behavioral supports, emergency and crisis planning, and disaster preparedness, as applicable.

c) Participants are informed of services available through the waiver in a variety of ways; prior to each DOH/DDD intake, and again at each annual ISP meeting. The DOH/DDD case manager provides and makes available and reviews the following:
i) the HCBS brochure, which lists the waiver services, eligibility criteria, other available services, and the process and timelines for admission into the waiver program;
ii) the Medicaid Waiver Providers in Hawaii booklet, which lists the services and the agencies that provide each service, including the geographic areas served by each agency. The booklet also contains questions the participant and/or legal guardian (if applicable) may want to ask the potential provider agency to help with service and agency choices. The booklet is updated periodically to reflect changes in waiver services and provider agencies; and
iii) the Consumer Directed (CD) Services brochure, which describes the consumer directed option for self-directed services.
The DOH/DDD provides outreach and informational sessions to various community groups, e.g. the Department of Education (DOE), job and transition fairs, conferences and other venues to provide information on available programs and services through the HCBS waiver.
The DOH also has a website describing waiver services.

d) The ISP shall be a written description of what is important to the participant to ensure delivery of services in a manner reflecting personal preferences, how any issues of health and safety shall be addressed, and what needs to happen to support the participant his/her desired life. The ISP identifies the strengths, needs (clinical and support), and desired outcomes of the participant to also

include:
i) how the participant communicates; (e.g. primary language, through gesturing, communicative devices, sign language, etc.);
ii) based on input from the DOH/DDD self-advocates, the following are included within the What's Important and Meaningful to Me section of the ISP; where the participant wants to live and with whom, health supports, well-being, safety supports, employment preferences, learning new things, relationships, leisure and recreation, what things the participant does not want in his/her life, opportunities to engage and receive services in the community, having the control of personal resources and other significant interests and preferences as identified by the participant (e.g. cultural, spiritual, religious traditions/celebrations, etc.);
iii) a discussion with the participant, guardian (if applicable) and circle of support regarding written information from the participant's medical, waiver provider and specialty medical reports. Other documents used include the case management assessments, and other reports (e.g. speech, occupational, educational, etc.) that will be integrated into the participant's individualized service plan as agreed upon by the participant and guardian (if applicable);
iv) priority goals and outcomes based on the participant's personal preferences, related to relationships, community participation, employment income and savings, healthcare and wellness. Interviews are also completed with the participant to identify other choices as indicated in the what's important and meaningful section of the ISP;
v) The action plan describes the details to meet the participant's goals, preferences, outcomes, health care needs, risk and safety needs and other significant interests;
vi) the action plan identifies the providers, services (waiver and other services) and supports needed to meet the participant's goals, outcomes, and personal preferences. This also includes unpaid supports provided voluntarily;
vii) the action plan also identifies the participant's risk and safety concerns to include the necessary supports to minimize the risks and safety concerns;
viii) the action plan shall include what services are delivered through the consumer directed services option; and
ix) the DOH/DDD case manager will complete an action plan revision for any changes that may occur during the 12-month period of the ISP. The waiver agency, DOH/DDD case manager, participant and/or guardian (if applicable) will sign the revised action plan for each change.
The frequency, duration, and timelines for services are specified in the action plan and agreed upon by the participant, guardian (if applicable) and his/her circle of support.

e) During the ISP there is a discussion and decision on how waiver and other services are coordinated and this is recorded in the ISP action plan. These discussions during the ISP meeting may be facilitated by the participant/guardian (if applicable) and the DOH/DDD case manager and within the ISP action plan the person responsible for the services and implementation will be identified. For waiver services the participant/guardian (if applicable) selects a provider from the Medicaid Waiver Providers in Hawaii booklet. The participant/guardian (if applicable) is also informed of the consumer directed services option where they are able to self-direct their own services. Participants/guardians (if applicable) have the option to receive some of their waiver services from Medicaid waiver providers and at the same time self-direct their services through the consumer directed services option. As needed, the participant's QI health plan and DHS are included to facilitate any medically necessary coordination.
i) Waiver services shall not supplant or duplicate services provided by another state agency to include but not limited to the Department of Education, Division of Vocational Rehabilitation, Child and Adolescent Mental Health Division, EPSDT services through the DHS health plans, Adult Mental Health Division, and other private agencies;
ii) services are coordinated by the DOH/DDD case manager's review of the plans from the agencies listed above with the participant and/or guardian (if applicable). The DOH/DDD case manager shall also arrange for, gather the necessary documents and assist the participant with the application process for services through other agencies as identified by the participant and/or guardian (if applicable). Coordination of services will also include discussions facilitated by the DOH/DDD case managers with the state health plans, community agencies and other agencies as identified through the ISP process with the participant and/or guardian (if applicable); and
iii) the DOH/DDD case manager provides the participant with the option to facilitate their ISP meeting and coordinate the services/supports and is available to help the participant/ guardian (if applicable) who requests any assistance with the facilitation and coordination of their ISP.

f) During the ISP meeting, assigned responsibilities are documented to include the frequency of services/supports as agreed upon by the participant/ guardian (if applicable), DOH/DDD case manager, and circle of support following the review of the participant's needs, preferences, assessments, reports by clinical professionals, waiver provider recommendations and other reports;
i) the ISP action plan section identifies the participant's services/support, frequency and duration, start date, the name of the agency, phone number, and the signature of the representative providing the supports. The participant/ guardian (if applicable) or personal representative also signs the action plan page along with the DOH/DDD case manager;
ii) monitoring of the implementation of the ISP is the responsibility of the DOH/DDD case manager with consultation from the participant/ guardian (if applicable);
iii) following the Hawaii Administrative Rules (HAR) chapter 1738 governing targeted case management DOH/DDD case managers conduct at least quarterly face-to-face contacts and periodic telephone contacts with the participant and /or guardian (if applicable), other agencies and the circle of support to assess/re-assess the participant's goals, outcomes, any health concerns, preferences and recommendations;
iv) during the quarterly face-to-face contact, the case managers shall complete a written quarterly/monitoring review form identifying the progress/status of the participant's goals, needs, desired outcomes, preferences, service delivery, health and safety concerns, and requested updates;
v) DOH/DDD case managers will provide appropriate action and follow up by revising the ISP action plan as changes occur (e.g. unnecessary or inappropriate services/supports or the need for additional services/supports) following a discussion with the participant/ guardian (if applicable);
vi) the DOH/DDD case managers shall also review the action plan page with the participant/ guardian (if applicable) to ensure

services and supports are delivered and implemented by the identified service providers (i.e.. paid and unpaid) in alignment with the ISP;
vii) the participant/ guardian (if applicable) signs the Action Plan(s) and Consent for Services forms to verify agreements made during the planning process. The consent form includes information about the steps a participant/guardian can take when disagreements occur. Should the participant and legal guardian (if applicable) elect not to sign or consent to the ISP, the DOH/DDD case manager shall include supporting documentation within the participant's contact log describing the efforts to resolve any discrepancies. A Notice of Action suspending waiver services will be issued to the participant and legal guardian (if applicable) that include appeal rights; and
viii) a copy of the ISP is also given to the circle of support members to verify agreements/assignments and conditions of what needs to happen, as needed.

g) ISPs are completed within 12 months and may be updated at any time as requested by the participant/ guardian (if applicable) and when a participant's needs/goals change or if there are changes in the service/support delivery;

h) all participants shall be present at their ISP meetings unless they choose not to be there. The DOH/DDD case manager shall document within the ISP whether or not the participant is present at their meeting; and

i) participants shall have the opportunity to conduct and facilitate their ISP meeting and may request assistance from their DOH/DDD case manager with this process. The DOH/DDD case manager shall document within the ISP whether or not the participant facilitated their meeting.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

i) Chapter 333F, HRS, and HAR Title 17 Chapter 1738 identify the critical case management functions of assessment, planning, and ongoing monitoring and service coordination;

ii) DOH/DDD case managers review the participant's assessments (verbal reports from circle members, direct observation of the participant by the DOH/DDD case manager and circle of support (including direct workers), written reports by clinical and other professionals, Inventory for Client and Agency Planning (ICAP) information that identify needed supports and services to minimize existing or potential risk factors;

iii) Information in the ISP is reviewed every 12 months and as the participant's needs or preferences change. Any potential or existing risk factors or conditions are addressed in the participant's Action Plan.

iv) other assessments such as the service planning assessment, e.g. ICAP, may also identify behavior issues and concerns;

v) the quarterly reports from providers and Adverse Event Reports (AER) may also identify other issues which may need to be addressed in the ISP;

vi) the "My Information" section of the ISP identifies contingency plans/back up supports for participants in the event of a natural disaster, emergency or behavioral crisis. The following information is also listed in this section to assist support workers and waiver providers in assisting the participant: health information identifying conditions and contact persons, physician contact numbers, dates of prescribed medications/dosages and the purpose of each medication, list of allergies, special diets, use of any adaptive or specialized equipment, financial, guardian (if applicable) or family/friends contacts and medical insurance plan information;

vii) the DOH/DDD Clinical Interdisciplinary Team (CIT) is the forum for discussion of issues representing medical and/or behavioral challenges/dilemmas. Recommendations of follow up activities from the CIT are provided to the DOH/DDD case managers who then share the information with the participant/ guardian (if applicable), waiver provider, families as applicable, for consideration in the action plan that is sensitive to the participant's preferences;

viii) ISPs include "contingency plans" developed to ensure identification of persons of agencies responsible for various actions and activities; as part of person-centered planning, the roles and responsibilities of the circle of support members may include the identification of a natural support, e.g., family member or neighbor, willing to provide back-up supports. Particularly for individuals with challenging behaviors, a crisis contingency plan is developed to ensure that there is clear communication of what needs to happen during a crisis; and

ix) the provider agreements include the requirement that the waiver provider agency shall have a plan identifying risk and safety factors, e.g. available reliever or back-up staff when the assigned primary direct service worker is unavailable. Further, when necessary, a second provider agency (which is also authorized to render the service required by the service plan) may be identified as "back-up" provider agency at the service plan meetings at which time the details of contacts and other arrangements are

clarified. This second agency would be used when the primary agency, as a result of unforeseen circumstances, may be unable to serve the participant. Copies of the ISP are provided to each agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

i) Upon admission to the waiver, participants receive information regarding the availability of qualified providers of each service in each geographic location statewide. As described in Appendix D-1 c (a) participants are informed of services available through the waiver in a variety of ways;

ii) participants are supported in selecting providers. The DOH/DDD case manager reviews the HCBS brochure with each participant. The HCBS brochure lists the waiver services, eligibility criteria, and the process and timeline for admission into the waiver program. Each participant receives a copy of this brochure. Participants may also use the Medicaid Waiver Providers in Hawaii booklet, which lists the waiver services and the agencies that provide each service. It also includes a list of questions so participants or potential participants are free to select service providers. Waiver services and providers are also listed on the DOH/DDD website;

iii) DOH/DDD case managers encourage participants to call and visit agencies to discuss specific questions and comments with agency representatives; and

iv) participants/ guardians (if applicable) may choose one or more service providers for one or more services. The choice of providers is discussed during the ISP meeting. Participant's choice of providers is documented in the ISP Action Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

i) DOH/DDD conducts monitoring on an annual basis utilizing the CMS sampling guide; and

ii) on an annual basis, DHS/MQD will validate a sample of ISPs by reviewing 10% of the non-compliant ISPs reviewed by DOH/DDD. Should be discrepancies be identified, a plan of correction is implemented by DHS/MQD to DOH/DDD for remediation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

◉ **Other schedule**

Specify the other schedule:

Service plans are reviewed no less than annually or when significant changes occur which require service plan updates or upon request of the participant or guardian (if applicable).

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [x] **Operating agency**
- [ ] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) DOH/DDD case managers shall monitor the implementation of the individualized service plan (ISP) and the participant's health and welfare;

b) DOH/DDD case managers at minimum perform quarterly face-to-face visits with the participant and make contact with caregivers, parents, guardians (if applicable), providers, teachers, and employers (as appropriate) and other persons and entities involved with the participant;

i) DOH/DDD case managers assess/review the participant's satisfaction with current services, health status, opportunities for choice, any new health and safety issue and how it will be addressed, and any needed follow-up. Case managers are required, by HAR Title 17 chapter 1738, to do "periodic observations of service delivery to ensure that quality service is being provided" as well as "evaluate whether a particular service is effectively meeting the needs of the recipient";
ii) DOH/DDD case managers obtain information from the participant and service provider (waiver or other service provider). For waiver services, quarterly reports are provided by the home and community based services (HCBS) providers. The DOH/DDD case managers are able to review whether the services are being provided in accordance with the action plan, the participant's progress and determine if the goals and outcomes are being met. This information is also used for discussion and potential ISP updates. The DOH/DDD case manager monitors participant's access to waiver and non-waiver services, effectiveness of back up plans, including health services in the quarterly review form. Within the Action Plan, the participant is free to choose their provider or the self-directed option;
iii) as problems are identified in the quarterly review form, the DOH/DDD case manager will provide follow-up activities with the participant/ guardian (if applicable);
iv) DOH/DDD case managers document any unmet needs and gaps in services based on the assessments, development of the ISP, monitoring of services and completion of the quarterly review form, which is reported to the DOH/DDD administration;
v) Adverse Event Reports sent to the case managers are reviewed for critical event, actions taken (or not taken), and any corrective action plans made. Upon notification of an adverse event that may pose jeopardy to health and welfare, the DOH/DDD case manager will immediately follow up to ensure the participant's health and welfare. In situations where there is an informal report or question concerning appropriate action(s) to be taken, DOH/DDD case managers will follow up with the person(s) or agency(ies) as necessary;
vi) completed Adverse Events Reports are sent to the DOH/DDD staff who review the actions and plans of corrections. DOH/DDD staff may also do follow up reviews with case managers and providers (residential and/or waiver). DOH/DDD staff also work with DHS staff (including Adult Protective Services (APS) and Child Welfare Services (CWS)) to address issues of abuse and neglect. Joint visits with the DOH/DDD case manager and APS or CWS may be completed to review and address a situation with the waiver provider;
vii) DOH/DDD case managers and other DOH/DDD staff may conduct follow up visits or telephone calls in response to issues identified by a participant, legal guardian (if applicable), interested party, or provider, at any time. DOH/DDD case managers, DOH/DDD staff, and DHS staff may also respond to and follow-up on issues of concern identified from Adverse Event Reports. Examples of these may include: providing participant related information to DOH/DDD case managers for their follow up, requiring corrective action plans from providers or DOH/DDD staff and ensuring corrective action plans have been implemented;
viii) monitoring of service plans is done at three levels:
1) at the individual level, by the DOH/DDD case manager;
2) at the program level, by the DOH/DDD internal monitoring quality team (non-case managers); and
3) at the oversight and system level, by DHS; and
ix) DOH/DDD shall also monitor a representative sample of the ISPs on an annual basis (refer to performance measures). DHS will oversee the DOH/DDD monitoring and review non-compliant records. Programmatic and systemic reviews are completed by DOH/DDD and DHS/MQD to identify areas of concern. Systemic changes/improvements may include revisions of operational policies and procedures, modification of forms or training procedures and identification of new training topics, among others.

Quality assurance monitoring of case management services is conducted annually by the DOH/DDD/OCB staff. Retrospective record reviews of randomly selected participants are conducted to ensure compliance with waiver requirements and ISP policies. When remediation is required by the case management unit, a report of findings is provided to the supervisor identifying service plan implementation or health and safety issues that need to be addressed. The supervisor is responsible for addressing all areas of concern within a specified timeline. Aggregate data from the case management monitoring reviews is collected and reported to DHS/MQD on a quarterly basis. This data is used at the program level for system improvement.

b. **Monitoring Safeguards.** *Select one:*

◎ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of waiver participants whose individualized service plans (ISPs) include services & supports that align with their needs as indicated in assessments (exclude health & safety risk factors). N: # of waiver participants whose ISPs include services & supports that align with their needs as indicated in assessments (exclude health & safety risk factors) D: Total # of waiver participants sampled

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants whose ISPs include services and supports that align with their needs as indicated in their assessments. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
#/% of waiver participants whose ISPs include supports to ameliorate assessed risk factors. N: # of waiver participants whose ISPs include supports to ameliorate assessed risk factors D: Total # of waiver participants sampled whose ISPs identified risk factors

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants whose ISPs include supports to ameliorate assessed risk factors. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☑ **Other**

	Ongoing	Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
#/% of waiver participants whose ISPs support the participants' personal goals. N: # of waiver participants whose ISPs support the participants' personal goals D: Total # of waiver participants sampled

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants whose ISPs support the participants' personal goals. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of participants who are present at their person-centered planning meeting to develop the Individualized Service Plan (ISP) N: # of participants who are present at their person-centered planning meeting D: Total # of participant records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of waiver participants with an ISP updated within 365 days of previous ISP. N: # of waiver participants with an ISP updated within 365 days of previous ISP D: Total # of waiver participants sampled

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants with an ISP updated within 365 days of previous ISP. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
#/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update. N: # of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update D: Total # of waiver participants sampled who had a change in their needs/condition requiring an ISP update

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of waiver participants whose services (type, amount, frequency, duration) were provided as specified in their ISPs. N: # of units of paid claims for each waiver participant D: Total # of units of prior authorizations for each participant

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual Claims Audit

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% review of the participant records selected as part of the provider's annual review
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager. N: # of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager D: Total # of waiver participants sampled

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

	Specify:

Performance Measure:
#/% of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager. N: # of records validated by DHS/MQD D: Total # of reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:

#/% of waiver participants with documentation of choice offered among available providers.
N: # of waiver participants with documentation of choice offered among available providers D: Total # of waiver participants sampled

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA/QI Review for Case Management Services

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants with documentation of choice offered among available providers.

N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
#/% of waiver participants with documentation of choice offered to self direct if applicable. N: # of waiver participants with documentation of choice offered to self direct if applicable D: Total # of waiver participants sampled receiving services for which self direction is an option

Data Source (Select one):
Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of waiver participants with documentation of choice offered to self direct if applicable. N: # of records validated by DHS/MQD D: Total # of records reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data	**Frequency of data**	**Sampling Approach** *(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Validation record review
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

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

b. Methods for Remediation/Fixing Individual Problems

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

Scheduled record reviews and satisfaction surveys performed by DOH/DDD assist in identifying individual as well as systemic problems. If a record is found to be out of compliance, e.g. ISP was not updated, DOH/DDD is responsible to ensure that the ISP is updated and to track and document this when completed. DOH/DDD submits the record review and

survey results to DHS/MQD. DHS/MQD performs its own review of records reviewed by DOH/DDD that were determined to be out of compliance.

ii. **Remediation Data Aggregation**

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

c. **Timelines**

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

◉ **No**

Yes

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

Yes. The State requests that this waiver be considered for Independence Plus designation.

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) Under the Consumer Directed Service option, participants and/or their designated representatives exercise Employer Authority to hire, train, supervise, and when necessary, discharge their direct support workers. The Consumer Directed Service option is available for the following services: Chore, Personal Assistance/Habilitation, Respite, and Non-Medicaid Transportation. Participants may direct one or more of their services. Participants may designate the support of a representative including a legal representative (for example, a guardian) or a non-legal representative. The designated representative is chosen specifically to support the participant in exercising Employer Authority.

b) During the Individualized Service Plan (ISP) development process, the case manager informs the participant of the Consumer Directed Service option. If the participant expresses interest, he or she participates in an orientation to learn more about the benefits, responsibilities and liabilities of this option. If the participant elects to self-direct services, a meeting is held with the participant, designated representative and case manager to further develop the ISP and determine how the participant will exercise Employer Authority, including what supports are needed.

c) Many individuals and entities support participants who use the CD Services option. Information and Assistance is provided by the DOH/DDD Consumer Directed Specialist and other DOH/DDD case management personnel. Information and Assistance training is also provided by the University of Hawaii at Manoa, Center for Disability Studies (Hawaii's University Center for Excellence in Developmental Disabilities). The participant's case manager monitors implementation of the CD Services option as well as monitoring of services and works with the participant and any designated representative to addresses any unresolved issues regarding the health, safety and delivery of services as indicated in the ISP. Participants are assisted with financial management services by the CD Specialist and staff to understand billing and documentation responsibilities, validate workers' eligibility to work in the United States, collect and process worker timesheets, and track hours used and hours authorized in the ISP. A fiscal intermediary performs payroll and employer-related duties of withholding and filing federal, state, local and other tax and insurances.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

◎ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☐ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

_____

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one)*:

Waiver is designed to support only individuals who want to direct their services.

◎ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) A variety of written materials about the Consumer Direction option are available to all waiver participants. These include the Consumer Directed Brochure, the HCBS brochure and the Developmental Disabilities Council Guide for participants receiving HCBS.

During the ISP development process, the case manager shares the CD Option and provides the participant and his or her representative (if applicable), the Consumer Directed Brochure.

Once the participant decides to participate in the Consumer Directed Services option, more information is provided in the CD orientation. Each participant and the designated representative (if applicable) receive a consumer directed services handbook that is used and reviewed in the orientation. The orientation includes the benefits and responsibilities of the Consumer Directed Services option, employer and employee responsibilities, providing techniques and suggestions for recruiting, screening, and hiring direct support workers, the responsibility to stay within the hours/authorization for each service, and the tax and legal employer forms and responsibilities. As an alternative option, participants and/or their designated representative may view the online version of the consumer directed services handbook and the necessary forms. This format will be available beginning in SFY 2017. Information on consumer directed options are available on an on-going basis from the DOH/DDD case manager and DOH/DDD Consumer Directed Specialist.

b) The DOH/DDD Consumer Directed Specialist and DOH/DDD are responsibility for furnishing the necessary information to the participant and/or designated representative.

c) Information is presented at the initial service planning meeting and at least annually or upon request. As stated, this option is included in the HCBS brochure which is also distributed upon admission into the waiver and as applicable. A waiver participant can request information on the Consumer Directed Services option at any time.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

The State does not provide for the direction of waiver services by a representative.

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

During the person-centered planning process, the choice of consumer directed services may be made. In such situations, if there is no legal representative of the person or if the adult person freely chooses a non-legal representative, the circle

members should assist to ensure that this non-legal representative chosen by an adult participant is someone who supports choices and decisions by the participant and who will not directly (or indirectly) benefit financially. Ideally, the non-legal representative is one who has a personal interest and relationship with the adult participant. The participant, their guardian or non-legal representative may initial the acknowledgement in the ISP action plan attesting that the participant has a choice of selecting the consumer directed services option.

In order to minimize potential conflict of interest and to provide safeguards for the participant, the DOH/DDD has affected policies and procedures defining who may not be designated representatives. For example, DOH/DDD cannot pay the representatives, who may direct waiver services on behalf of the participant. As situations arise, DOH/DDD provides technical assistance and supports to address how and what supports may be provided to ensure that the participant receives quality services in a manner desired by the individual and in the individual's best interests.

The Consumer Directed Specialist assists case managers and individual participants and/or designated representatives regarding procedures for enrollment and payment. The DOH/DDD monitors consumer-directed providers as part of its quality monitoring. DHS/MQD oversees DOH/DDD's monitoring of consumer-directed providers.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Assistance/Habilitation (PAB)	☑	☐
Respite	☑	☐
Non-Medical Transportation	☑	☐
Chore	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

◎ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Under the Employer Authority, the FMS will be required to support the participant to meet all state and federal statutory requirements through payroll processing. The FMS is selected through an administrative selection process.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The agent is paid a flat fee per check issued. Compensation to the payroll agent is fully state-funded.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☐ **Assist participant in verifying support worker citizenship status**
- ☐ **Collect and process timesheets of support workers**
- ☐ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Fiscal oversight is provided by the DHS/MQD Financial Office which reviews various summary reports that are produced in conjunction with the monthly payroll process.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

During the participant-centered planning process, case managers explain services and service options including consumer directed services as defined in E-1-e. The Consumer Directed Specialist will provide ongoing support to the participant and his/her case manager throughout the participant's use of this option to process and submit required documentation.

The participant may use consumer directed personal assistance exclusively or in conjunction with agency managed services. They may change their selection at any time.

The case managers monitor the delivery of consumer-directed services on a quarterly basis.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Assistance/Habilitation (PAB)	☐
Environmental Accessibility Adaptations	☐
Discovery & Career Planning (DCP)	☐
Waiver Emergency Services	☐
Personal Emergency Response System (PERS)	☐
Respite	☐
Residential Habilitation (ResHab)	☐
Assistive Technology	☐
Individual Employment Supports	☐
Training and Consultation	☐
Non-Medical Transportation	☐
Chore	☐
Skilled Nursing	☐
Specialized Medical Equipment and Supplies	☐
Adult Day Health (ADH)	☐
Vehicular Modifications	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The case manager works with participants during the person centered planning process to identify the type and amount of supports needed. Participants may use consumer directed personal assistance exclusively or in conjunction with agency managed services. They may change their delivery method at any time; in general, back-up plans are required for participants using the consumer directed option, including identifying back-up natural supports, consumer directed workers and agency provider(s). When participants voluntarily terminate the consumer directed option, the case manager re-assesses the needs of the participant and authorizes the appropriate number of agency hours.

The case manager will assure the health and welfare of the participant; no services are terminated until needed substitute services, either by an agency or natural supports, are being provided.

Natural supports will not supersede the transition to provider supports.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Circumstances:
a) when participant's preferred direct support worker is unable or unwilling to provide the service and there are no options desired by the participant;
b) when participant's preferred direct support worker has been confirmed as a perpetrator of abuse (including financial) and/or neglect of the participant;
c) when the participant's preferred direct support worker(s) do not or cannot provide appropriate services, potentially endangering the participant's health and welfare;
d) when there is no back-up available; and
e) when the participant or his designated representative continually fails to meets consumer directed program requirements, e.g., untimely submittal of vouchers, submittal of incorrect vouchers, failure to deliver payment to workers, failure to maintain service records, failure to train and monitor workers, failure to follow the ISP activities and authorized hours, etc.

For participants who utilize the consumer directed option, the case manager generally is the first line of quality assurance, providing regular ongoing monitoring. Prior to starting consumer directed services, the participant and/or his designated representative shall have a back-up plan in place. Back-up plans include natural supports, other consumer directed workers and/or a provider agency to assure ongoing supports – it is preferable to have at least two natural supports and/or consumer directed workers and a provider agency, as a final back-up to provide services. In situations where the participant's health and welfare may be in jeopardy, the case

manager may immediately effect the implementation of the back-up plan after discussion with the participant and/or designated representative; the case manager may take other appropriate action if necessary (including referral for protective services assistance.) The case manager will, during the transition, facilitate access, coordinate, monitor and assess the need for supports, e.g., other waiver services or other types of services.

The case manager will assure the health and welfare of the participant, arranging for agency provided services or natural supports as soon as the case manager is aware of the need.

Natural supports will not supersede the transition to provider supports.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	675	
Year 2	700	
Year 3	725	
Year 4	750	
Year 5	775	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

If desired by the participant, criminal history checks may be viewed at no cost using local registry sites.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The individual (or his/her legal representative) is informed of the opportunity to request a fair hearing at various points in the process of admission and service delivery. For purposes of this section, the term "individual" means a person who is applying for, but not yet determined eligible for, the waiver and includes his/her legal representative. The term "participant" means a person who is eligible for and enrolled in the waiver and includes his/her legal representative.

As part of the waiver application and enrollment process, individuals are provided information about waiver home and community-based services (HCBS) at the first meeting with the DOH/DDD case manager. At the initial meeting, the DOH/DDD case manager explains the difference between institutional services and waiver HCBS, the HCBS waiver program and HCBS requirements (Medicaid eligible, meet Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID] level of care, information requirements, etc.), and gives the individual a choice between institutional services or HCBS. Formal written notice and information about how to request an administrative hearing are provided to any individual determined to be ineligible for the waiver.

Once enrolled in the waiver, participants, the DOH/DDD case manager provides the DOH/DDD HCBS and Appeals brochures. These brochures provide information on the process for appealing any adverse action taken by the DOH/DDD on waiver services. Participants are provided the option of requesting an informal process with DOH/DDD prior to the formal administrative hearing at DOH/DDD or DHS/MQD. DHS/MQD and DOH/DDD Information about Grievance and Appeals is provided at least annually at the person-centered planning meeting by the DOH/DDD case manager.

During the course of reevaluating the participant's level of care, needs and services, the DOH/DDD case manager informs participants of their right to appeal where there is any adverse action, (i.e., when waiver services are suspended, reduced or terminated). Participants are informed of the right to be notified in advance of the adverse action being taken, the right to request an informal review by DOH/DDD, and the right to request an administrative hearing before a DOH/DDD Hearing Officer and a DHS/MQD Hearing Officer. Participants are advised of the right to be represented by a representative at the hearing. Participants are informed that current services continue during the pendency of the information review and appeal. Participants are informed of the right to forgo the informal review with DOH/DDD and proceed directly with an administrative hearing with either DOH/DDD or DHS/MQD.

Where waiver services are suspended, reduced or terminated, the DOH/DDD case manager completes a Notice of Action (NOA) form to inform the participant of the adverse action and the reason for the action. The Notice of Action form is provided at least ten (10) working days prior to the action being taken, per Hawaii Administrative Rules (HAR) § 11-88.1-10(b) except in circumstances as defined in HAR §17-1713(1)(c) where adequate notice shall be sent not later than the date of the action. A copy of the Notice of Action form is kept in the participant's case file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   ◉ **No. This Appendix does not apply**

   Yes. The State operates an additional dispute resolution process

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

No. This Appendix does not apply

◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The DOH/DDD handles grievance/complaints relating to the DOH/DDD eligibility and waiver services.

Participants are informed that filing a grievance or making a complaint are not pre-requisites or substitutes for a Fair Hearing.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) The DOH/DDD has a Consumer Complaints Resolution Unit (CCRU) that is responsible for receiving concerns/complaints/appeals for DDD services. These are issues that have not been resolved at either the case management unit level, provider level, or system level. These issues may include complaints against case managers, about a process or processes that did not occur as perceived by the complainant, about service delivery, and about decisions affecting service delivery. The DOH/DDD is responsible for receiving the complaints/concerns and tracking them to ensure they are handled in a timely manner.

b) Complaints may be registered verbally or in writing by email or letter. Initial response to complaints is provided within 24 hours, or the next working day following receipt. Timeline for resolution of complaints is one month.

c) The CCRU gathers information related to the complaint from the case manager, provider or other party with information about the complaint. The CCRU attempts to resolve the complaint by identifying the action(s), if applicable, that could improve the situation. If the complaint is related to a DOH/DDD employee, if appropriate, the complainant is referred to the Department of Health Personnel policies and procedures regarding labor relations.

Participants are informed that they are able to request a Fair Hearing and that the use of the Grievance process does not replace a Fair Hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

No. This Appendix does not apply *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As indicated in the Division's Adverse Event Report Policy, all waiver providers, DOH/DDD case managers, consumer-directed employers, adult foster home certified caregivers, and individuals involved with the participant, e.g., families, guardians (if applicable) and workers, are required to report occurrences of the following adverse/critical events on the Adverse Event Report (AER) Form:

1) suspected abuse, neglect, or financial exploitation of a participant. Abuse includes physical, psychological, and sexual abuse. An incident in this category must also be reported to Adult Protective Services (APS) or Child Welfare Services (CWS) pursuant to Section 346-222, Hawaii Revised Statutes (HRS) and Section 350-1, HRS;

2) injuries of a known or unknown cause requiring medical or dental treatment rendered by ambulance or emergency medical

personnel, urgent care or emergency room medical staff or dentist, or results in hospitalization;

3) medication errors that include wrong medication, wrong dose, wrong time, or missed dose;

4) changes in the participant's behavior, including but not limited to aggression, self-injurious behaviors, property destruction, sexualized behaviors that may require a new or updated Behavior Support Plan as a result of the intensity and/or severity of the behavior;

5) changes in the participant's health condition requiring medical or dental treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical staff or dentist, or results in hospitalization;

6) death of a participant;

7) whereabouts unknown regardless of the amount of time a participant was missing or unaccounted for;

8) any use of restraints such as chemical, mechanical, and physical; and

9) any use of seclusion in which the participant is confined to a room/area and prevented from leaving by closing the door or using another barrier.

All adverse events are reported to the DOH/DDD case manager. All Waiver Providers, Consumer-Directed Employers, and Adult Foster Home Certified Caregivers must make a verbal report within 24 hours or next working day of the critical event and submit a written AER form within 72 hours (exclusive of weekends and holidays) to the DOH/DDD case manager. Based on the available information, the DOH/DDD case manager must assess if there is potential for further injury or harm to the participant and/or others in the home or program setting, and notify his/her supervisor immediately. The supervisor in consultation with his/her section supervisor, Case Management Branch Chief, DOH/DDD Administrator, and DOH/DDD Medical Director will determine if an initial onsite assessment is warranted and identify the DOH/DDD staff who will be conducting the assessment.

For incidents involving alleged or suspected abuse, neglect, or exploitation, within 24 hours of receiving the verbal report, the DOH/DDD case manager must gather relevant information (date, time, and location of the event, identify persons involved, identify alleged perpetrator), assess the extent of injury or harm to the participant, verify actions taken to provide for the participant's immediate safety, and confirm if a report was made to APS or CWS. If a report to APS or CWS was not made, the DOH/DDD case manager shall make a report immediately. The DOH/DDD case manager shall notify his/her supervisor of the allegations and conduct a face-to-face interview with the participant to determine if additional medical treatment or actions are necessary to safeguard the participant. If the participant has a legal guardian and it is believed that the legal guardian is not involved in the incident, the DOH/DDD case manager will inform the guardian of the situation and discuss a recommended plan of action. The DOH/DDD case manager shall work in collaboration with the APS or CWS worker and notify the respective licensing and certifying agency if the participant resides in a licensed or certified home.

As indicated in the Mandatory Reporting of Abuse and Neglect Policy, all DOH/DDD employees are mandated to report and follow-up on any allegations or incidents of suspected abuse, neglect, and/or exploitation of DOH/DDD participants. DOH/DDD employees shall comply with all HIPAA requirements related to the disclosure of protected health information to APS, CWS, and police, as referenced in this policy.

Upon receipt of the written AER form, the DOH/DDD case manager is responsible for:

1) documenting whether reporting timelines were met;
2) determining if the information in the report is accurate and complete and if not, requiring the reporter to re-submit an updated/revised report;
3) assessing the appropriateness of the immediate action taken to safeguard the participant;
4) assessing the appropriateness of the plan of action to prevent the recurrence of the event;
5) ensuring the participant's health and safety by making a face-to-face visit with the participant or phone contact with the reporter to get an update on the participant's current status;
6) assessing if additional actions are warranted to prevent the recurrence of the event;
7) updating the participant's Individualized Service Plan if there are risks factors that need to be addressed and identifying the supports to minimize the assessed risks; and
8) conducting ongoing monitoring of services to assure implementation of any corrective action plans. At a minimum, the DOH/DDD case manager shall consult with the unit RN or RN designee for all adverse events involving medication errors, changes in the participant's health condition requiring medical or dental treatment, and when an adverse event results in hospitalization.

The DOH/DDD case manager is responsible for documenting all actions taken in response to the event on the AER form and submitting the report to his/her supervisor for review and signature. This part of the AER form must be submitted to the Waiver Provider, Consumer-Directed Employer, or Adult Foster Home Certified Caregiver who reported the event within five (5) working days of receiving the written report.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have

experienced abuse, neglect or exploitation.

A DOH/DDD brochure on rights and responsibilities of a person with a developmental disability is available. Included in this brochure is a section on abuse including rights, signs, and actions to be taken. This brochure is shared with case managers for use as part of their discussions with participants and/or their legal guardian (if applicable) or designated representatives. This brochure is also incorporated in training for stakeholders, e.g., individuals (to be shared as part of self-advocacy training), families, case managers, providers, and other interested stakeholders.

Whenever allegations of abuse are made, the DOH/DDD case manager informs the participant and/or legal guardian (if applicable)/designated representative of the allegations, concurrently explaining reportable events according to the CWS and APS laws. The case manager, in further follow up discussions and queries with the participant or the participant's legal/designated representative, will discuss more fully, the participant's rights and the actions or inactions that are considered to be abuse, exploitation, or neglect.

The waiver providers are required to inform the participant and/or the legal guardian (if applicable) or designated representative of participant's rights, including being free from exploitation, neglect, and abuse. Additionally, the participant signs an acknowledgement form annually which reviews these rights.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Program Services Evaluation Unit (PSEU) is responsible for the oversight of the adverse event reporting system, which includes receiving and evaluating all adverse event reports, verifying that corrective action was implemented, and analyzing the information to identify trends/patterns and to make recommendations for quality improvement.

PSEU staff will evaluate each adverse event report to determine whether or not appropriate actions were taken to prevent the recurrence of the event and to assure the participant's immediate safety. Incidents involving suspected abuse, neglect, or exploitation are reported to APS or CWS, as appropriate. The PSEU staff will assure mandatory reporting requirements are met for incidents involving suspected abuse, neglect or exploitation of a participant.

When the AER form includes documentation ensuring the participant's health and welfare and there is a plan in place to prevent the recurrence of the reportable event, the AER is closed and no additional follow-up is required. If additional documentation or follow-up is required by the DOH/DDD case manager (form is incomplete or contains inaccurate information, or critical information is missing), the PSEU staff will notify the respective Case Management Branch staff and request that the additional information be submitted in writing. For events that require follow-up because of the potential to impact the health and welfare of the participant or others in the residential or program setting, the PSEU staff will notify the respective Branch staff overseeing the Adult Foster Home or Waiver Provider Agency and request a plan of action to address the identified issues.

Investigations will be conducted by PSEU staff and others designated by DOH/DDD for the following circumstances: Any death as a result of:

1) serious injury that required treatment in the emergency room or urgent care or resulted in a hospitalization;
2) medication error;
3) elopement;
4) unknown circumstances;
5) the use of restraint or seclusion; and
6) any and all other situations identified by the DOH/DDD Administrator or Outcomes and Compliance Branch Chief as requiring an investigation.

Investigations will be conducted within 72 hours of receiving the written AER form from the DOH/DDD case manager. Depending on the range of activities required to complete each investigation, the timeframe for completing an investigation may take up to 30 days. Within 14 days of completing the investigation, the participant's family or legal guardian, if applicable and other relevant parties will be informed of the investigation results.

All instances of suspected abuse and neglect must be reported to the DHS Adult Protective Services (APS) or Child Protective Services (CPS) intake units. DHS has policies and procedures to address the reports and resolutions. For waiver provider agencies, the Provider Service Agreement stipulates that they must inform the DOH/DDD case manager and DHS (APS or CPS) within 24 hours of the occurrence of a critical event and submit a written report within 72 hours.

For all other types of critical events or incidents as defined in G-1-b, the following process will be followed. When DOH/DDD case managers are notified of critical events, they are required to complete the Adverse Event Report (AER). The DOH/DDD case managers assess the information related to the adverse/critical event(s) that is submitted by the individual or agency, e.g. waiver Provider. DOH/DDD case managers are required to respond to critical incidents within the first working day; coordination with DHS (APS or CPS) is done as necessary to ensure coordinated service planning. DOH/DDD case managers provide follow-up activities by contact, through telephone calls or face-to-face meetings or both, with the participant or the participant's legal or designated representative, to insure that the participant is safe. They obtain additional information required to determine what follow-up actions may be necessary, i.e., alternate placement of participant into another living environment, revising the service

plan, arranging for a medical evaluation/follow-up treatment, providing more information to enforcement agencies, coordinating training or other supports, etc. Follow-up actions may include conducting on-site reviews and interviews with the collaterals. This may include a review of the provider in consultation with DHS to determine that corrective actions (for participant and by provider) are adequate. Following completion of interviews and fact finding, case managers inform the participant and/or guardian (if applicable) of the results, including recommended actions to be taken by the case manager, as these often include presenting options for different providers of particular services, e.g., residential, agency, direct support worker, etc. Investigations will be completed as soon as possible but typically within 30 days.

Data relating to critical events are analyzed and statistical reports prepared, e.g., information on trends, patterns, indicators of how services are rendered to each participant, etc. and reviewed by DOH/DDD for identification of issues of concern, i.e., trending analysis, corrective action plans (agency, case manager, supervisors) and follow-up action, e.g., monitoring, training, etc. In addition to responding to individual occurrences of adverse/critical events, emphasis would be on the adequacy of the Providers' ongoing Quality Assurance activities. Areas of deficiencies will be addressed by DOH/DDD and monitored by DHS.

For adverse/critical events, case managers and agency staff are expected to respond immediately to begin information gathering or the investigative processes. The timelines for reporting are previously addressed in this document. Actions taken by the direct support worker, agency, case manager, and/or APS or CPS are expected to be driven by the nature of the critical event and agency policies and procedures. Of foremost concern is the health and welfare of the participant.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Providers submit adverse/critical events on an Adverse Event Report (AER) form. These are collected, tracked, and reviewed by DOH/DDD using the database mentioned above. DOH/DDD follows guidelines that are issued by DHS/MQD and follows established policies and procedures.

DOH/DDD and DHS/MQD are responsible for overseeing that adverse/critical events, including all incidents of abuse and neglect, are reported and are satisfactorily addressed and resolved. The frequency of quality assurance reviews by DOH/DDD and reports received by DHS/MQD varies depending on the specific type of information gathered. Refer to Quality Improvement sections located at the end of this appendix for specific information and frequencies. An overview of this oversight includes:

1) review of all AERs submitted by DOH/DDD, which will comprise of an aggregation and analysis of 100% of AERs received. DHS/MQD will notify DOH/DDD if further remediation, corrective action, or system improvement is needed;
2) detailed review of AER Reports for all deaths; and
3) detailed review of AER Report for participants or providers that raise concerns based on monitoring trends.

All waiver providers are required to have an Internal Quality Improvement program that includes a process for providing ongoing monitoring, quarterly assessments and trending of Adverse Events for appropriateness of action taken, follow-up and preventive actions to be taken.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◎ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DOH/DDD's Positive Behavioral Support (PBS) P&P 2.01 ensures a PBS approach with all Waiver participants. It establishes practices to allow people to engage in adaptive and socially desirable behaviors for meaningful/productive lives. It also promotes participants' participation in integrated activities. The P&P sets forth core values of supporting

people by expanding opportunities and enhancing quality of life.

P&P 2.01 defines specific procedures for the development of behavior support plans (BSP) including that BSPs must be developed for people who engage in behaviors that threaten the health and safety of themselves or others, or that limits the participant from participation in an integrated activity. It requires the BSP be developed per Act 199 of 2015.

The purpose of P&P 2.01 is to limit/specify restrictive procedures to ensure restrictive measures are used only for the protection of participants from imminent harm to self or others; are used after less restrictive interventions have been attempted; participants are supported in caring, responsive environments free from abuse; supports are based on understanding the participant has reasons for their actions; and effort is directed at creating opportunities for participants to exercise choice.

Restrictive procedures are defined as procedures that restrict a participant's freedom of movement, access to property, or require a participant to do something which they do not want to.
Aversive procedures are intended to inflict pain, discomfort and/or social humiliation to modify behavior including electric skin shock, liquid spray to one's face and strong, non-preferred tastes applied in the mouth. These are prohibited.

"Behavior Support Plan" outlines the steps that will be taken by the members of the participant's team to modify the physical environment, teaching of replacement skills, how team members should respond to challenging behaviors, and ways to decrease the likelihood of challenging behaviors from occurring. The BSP is developed based on the results of a Functional Behavior Assessment (FBA).

"Chemical Restraint" means psychotropic medication prescribed by a licensed health care professional with prescriptive authority: on a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or the incidental use of medications, sometimes called PRN or as needed medication, to protect the participant from imminent harm to themselves and/or others through temporary sedation or other related pharmacological action. The P&P also defines actions that are not considered chemical restraints.

"Mechanical Restraints" means a restraint which a device, material or equipment is involuntarily applied to the participant's body or immediate environment that immobilizes, restricts, limits, or reduces any bodily movement. The P&P also defines devices that are not considered mechanical restraints and prohibitions.

"Physical Restraints" means a restraint in which physical force applied to the participant and involuntarily restricts their freedom of movement or normal access to portion or portions of their body. Refer to Policy 2.02 Restrictive Procedures for additional information and DOH/DDD parameters for use of Physical Restraints, including prohibitions and limitations.

"Restraints" means physical, chemical or mechanical interventions used as a last resort on an emergency basis to protect the participant from imminent harm to themselves and/or others using the least restrictive means possible and for the shortest duration necessary.

"Restrictive Procedures" means a procedure that limits a participant's freedom of movement, access to other locations, property, or rights.

"Seclusion" means a restrictive procedure in which a participant is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. This is prohibited.

The Restrictive procedure policy states these procedures may only be used for protection from imminent risk of serious harm to self or others, and may not be used in situations where there is no need for protection; only the least restrictive procedures to adequately protect the participant and others from harm shall be used, and restrictive procedures must be terminated as soon as the need for protection is over and/or a lesser restrictive intervention be effective.

C. The following interventions are prohibited:
1. Seclusions;
2. Aversive procedures involving electric shock (excluding medically administered electroconvulsive therapy); corporal punishment or interventions that cause physical pain or harm to a participant; unpleasant tasting foodstuffs or stimuli; and use of any noxious substances for the purpose of reducing a behavior.
3. Restraints that are prone, supine, restrict circulation or ability to breathe and/or excessive pressure on chest, lungs, sternum, and diaphragm, cause pain or harm to the participant; restraint chairs or boards; any maneuver that involves punching, hitting, poking, or shoving the participant; straddling or sitting on the torso any technique that restrains a participant vertically against a wall or post face first; and head hold where the head is used as a lever to control movement of other body parts.
4. Interventions involving: verbal or demonstrative harm caused by oral or written language, gestures with disparaging or derogatory implications; psychological/mental/emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment or deprivation; denial of food or beverage as a consequence of behavior;

disabling of or restriction of a communication device; placing a participant in a room with no light; overcorrection; and withholding or taking away money, incentives or activities previously earned.

Requirements concerning the use of alternative strategies to avoid the use of restraints:
The DOH/DDD promotes positive behavioral supports, eliminating restrictive and adverse procedures, supporting Waiver participants to be fully integrated into the community and having meaningful lives. BSPs must have a hierarchical strategy of interventions that start with the least restrictive intervention possible and only in emergency situations of threat or harm to self or others. Service Supervisors and Staff who work directly with participants with identified behavioral challenges requiring a BSP must be trained in a nationally-recognized training program approved by DOH/DDD. A component of the curriculum must include de-escalation and re-direction techniques to be utilized prior to a restraint. It must also include focusing on the participant's needs, the physical environment to provide alternatives to escalating behaviors. Staff must be trained on the participant's Behavioral Support Plan containing individualized and specific techniques to safely resolve situations and minimize restraints.

Unauthorized or misapplication of restraints are detected through the following methods:
A. All defined restraints are reported through the Adverse Events Reporting (AER). All reports are monitored by the DOH/DDD for unauthorized use of restraints, seclusions, misapplication or abuse and may require corrective action;
B. Quarterly monitoring by DOH/DDD case managers who are required to meet with the participant, review recent events and observe their interactions with staff;
C. The complaint and grievance process identifies any violation of rights or unauthorized use of restraints;
D. Provider monitoring occurs annually or when any violations of standards are detected. Annual monitoring includes review of records and direct discussions with Waiver participants;
E. Annual on-site Certification Reviews of each adult foster home; and
F. Case review of sample of cases to detect unauthorized use of restraints by DOH/DDD Clinical Intervention Team (CIT), who provides recommendations to prevent the misuse of restraints.

Participants restrained frequently, injuries resulting from restraints and other events such as hospitalization, are referred to the Behavior Supports Review Committee (BSRC). The BSRC reviews all aspects of care for the participant, recommends any additional assessments or information and advises on supports that could promote positive behavior. Current BSPs of any participants receiving a PRN medication for the purpose of behavioral control are reviewed by the BSRC. All provider agencies must have an internal policy that includes the use of restraints in alignment with the State's policy, the reporting of any use of restraints, and how unauthorized use or in application of restraints are detected and remediated.

The protocols that are followed when restraints are employed (including the circumstances when they are permitted and when they are not) and how their use is authorized:
DOH/DDD has a protocol for the use of restraints. Restraints may only be used when the following are in place:
- there is an imminent risk of harm to the participant or others;
- the professional writing the BSP possesses the required education and training;
- the participant and/or guardian (if applicable) has given informed consent to BSP;
- any staff involved in restraint must have documentation of being trained in positive behavior supports; the participant's BSP and a nationally recognized crisis intervention system approved by DOH/DDD;
- the participant's BSP outlines the hierarchy of least restrictive interventions, and are utilized and found to be ineffective prior to the use of restraint;
- the participant's BSP outlines the conditions that will indicate to staff that a restraint should be removed and a less restrictive intervention utilized;
- service supervisors trained in a nationally recognized crisis intervention system will facilitate debriefing of any use of restraint.

Restraints are not permitted when other less restrictive interventions would be effective; an imminent risk of harm to self or others is no longer present; or as a form of punishment.
The practices that are employed in the administration of a restraint to ensure health and safety:
Restraints are used only in emergency situations of imminent risk to self or others. The health and safety risk of the behavior must outweigh the risk of the restraint. The participant being restrained must be monitored throughout the use of restraint for health and safety. Monitoring includes continuous evaluation of the participant, including breathing, consciousness and effects such as pain; the participant's reaction to the restraint; the participant's behavioral condition; and, the need to terminate the restraints. Restraints are terminated immediately if there are any indications of health or safety risk and/or the earliest time safely possible.

Required documentation:
Providers shall maintain a record of the date, time, duration and antecedent of any restraint, evidence the provider first utilized positive and less restrictive interventions and that these interventions were not successful in deterring threat of harm. Records shall be shared with the case manager and participant's support team. Details will be communicated to DDD through the AER process.
Psychotropic PRN medications require the same documentation requirements as physical restraints and must also include documentation of the medication, dosage, behavior after administration, and side effects if present.
Education and training requirements that a provider agency personnel must meet who are involved in the administration

of a restraint:
Providers must show documentation of staff having training in the participant's individual BSP; positive behavioral supports introduction and overview; and nationally recognized crisis intervention system approved by DOH/DDD.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Both DHS/MQD and DOH/DDD are committed to ensuring that the use of restraints and seclusion are only used to protect the participant from immediate harm to self and others. DOH/DDD is responsible for overseeing the use of restraints by waiver service providers. Information on any incidence of seclusion or restraint is collected through the AER process. AER data on seclusion and restraints, including analysis of trends and patterns are reported quarterly by the DOH/DDD Outcomes and Compliance Branch to the BSRC, which completes a quarterly report and makes recommendations for quality improvement to the DOH/DDD Quality Assurance and Improvement Program (QAIP) Safety and Well-being Subcommittee of the QAIP Steering Committee Recommendations address programmatic, policy and/or systemic recommendations. BSRC, as a regularly reporter to through the QAIP process, and based on review of the data, develops performance measures related to the use of restraints as part of the QAIP Work Plan.

Issues related to provider agency performance are referred by the OCB or the BSRC to the DOH/DDD Provider Monitoring Section. If the issue requires an improvement plan or immediate corrective actions, the provider monitoring section requests, tracks and evaluates the implementation of improvement activities by the provider agency for effectiveness and addressing any core performance issues.

On an annual basis, DOH/DDD Certification Unit provides comprehensive monitoring of DOH/DDD Adult Foster Homes (AFH) as part of its certification process. The certification process involves records and on-site review of each AFH. Any incidents of seclusion or unauthorized use of restraints are cited for non-compliance with standards and corrections must be made. If any reports are made to the Certification Unit outside of the annual on-site inspection, Certification Unit staff conducts an investigation, and acts on any non-compliant practices to include requiring corrective actions.

The BSRC reviews individual cases with the highest rates of restraints and provides technical and clinical advice. The BSRC will look at trends to assist in necessary improvement. AER data on restraints is gathered on an ongoing and continuous basis. The Branch Chief for the Outcomes and Compliance Branch receives all reports of serious issues, and can implement investigations, request information, or intervene immediately if serious violations of DOH/DDD's standards are detected. Aggregate data are analyzed and reported quarterly to the BSRC who reports to the Safety and Well-being Committee of the QAIP Steering Committee. The BSRC analyzes, reviews data and makes recommendations quarterly. The Community Resource Branch conducts continuous provider monitoring basis, and site visits and conducted to each service site at least annually. As part of the annual monitoring visit, the process includes a review of a sample of records to identify any events, such as the use of restraints that were not reported as required. The provider must complete a corrective action plan (CAP) to address the participant-specific situation and revised policy, practice or other strategies the provider agency will employ to prevent further issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◎ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

First use of non-aversive methods:
The DOH/DDD promotes the concepts of positive behavioral support and is focused on eliminating restrictive and

adverse procedures, supporting people we serve to be integrated into the community and living meaningful lives. A positive approach assumes that all behavior has a purpose and that participant's behavior can be to communicate a need or a manifestation of a medical or clinical issue such as trauma.

Behavior support plans (BSP) with restrictive interventions are written to be proactive and minimize the occurrence of challenging behaviors via a primary focus on the use of positive interventions. Restrictive interventions are used only after lesser restrictive interventions have been attempted first and found not effective. All restraints must be a part of a Behavior support plan with a hierarchical strategy of interventions starting with the least restrictive.

The following interventions are prohibited:
1. Seclusions;
2. Aversive procedures involving electric shock (excluding medically administered electroconvulsive therapy); corporal punishment or interventions that cause physical pain or harm to a participant; unpleasant tasting foodstuffs or stimuli; and use of any noxious substances for the purpose of reducing a behavior;
3. Restraints that are prone, supine, restrict circulation or ability to breathe and/or excessive pressure on chest, lungs, sternum, and diaphragm, cause pain or harm to the participant; restraint chairs or boards; any maneuver that involves punching, hitting, poking, or shoving the participant; straddling or sitting on the torso any technique that restrains a participant vertically against a wall or post face first; and head hold where the head is used as a lever to control movement of other body parts;
4. Interventions involving: verbal or demonstrative harm caused by oral or written language, gestures with disparaging or derogatory implications; psychological/mental/emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment or deprivation; denial of food or beverage as a consequence of behavior; disabling of or restriction of a communication device; placing a participant in a room with no light; overcorrection; and withholding or taking away money, incentives or activities previously earned.

Staff who provide services to participants whose treatment plans include restrictive intervention(s) are trained in a nationally-recognized curricula approved by the DOH/DDD. A component of these curricula includes de-escalation and re-direction techniques to be used prior to a restraint as well as crisis management and intervention techniques. In addition, staff must be trained on the participant's behavioral support plan which focuses on utilizing non-aversive methods as a primary intervention.

Methods to detect the unauthorized use of restrictive interventions:
DOH/DDD employs multiple ways of detecting and addressing unauthorized use of restrictive interventions. All unauthorized restrictive interventions are reported and addressed through the AER process. Case managers monitor aversive methods in routine meetings with participant and report any suspected abuse or neglect. The BSRC reviews cases of people who have experienced injuries due to restrictive interventions and take referrals for people with behaviors that are difficult to manage. Unauthorized restrictive interventions may also be detected through the complaints and grievance process. Provider monitoring is another method to detect unauthorized use.

On an annual basis, DOH/DDD Certification Unit provides comprehensive monitoring of DOH/DDD Adult Foster Homes (AFH) as part of its certification process. The certification process involves records and on-site review of each AFH. Incidents of unauthorized use of restrictive interventions are cited for non-compliance with standards and corrections must be made. If any reports are made to the Certification Unit outside of the annual on-site inspection, Certification Unit staff conducts an investigation, and acts on any non-compliant practices to include requiring corrective actions.

Protocols for authorizing the use of restrictive interventions, including treatment planning requirements and review/reauthorization procedures:
All BSPs must follow guidelines on prohibitions of specified aversive methods and restrictive interventions. BSPs with specified restrictive interventions must have the informed consent of the participant, guardian (if applicable) and/or treatment team. BSPs are required to promote positive and proactive strategies to avoid restrictive procedures. Samples of BSPs are reviewed in provider monitoring for quality and compliance with state policy. Any BSP that includes a restrictive intervention for waiver participants with identified behavioral challenges that required a BSP is reviewed by the BSRC.
Required documentation when restrictive interventions are used:
To assess the efficacy of BSPs that are being implement, the documentation of behaviors, circumstances, restrictive interventions and effectiveness in addressing each incidence of targeted behaviors are needed. Adequate documentation is a key component of being able to monitor behaviors and evaluate efficacy of interventions for future BSP modification and improvement. BSPs should utilize documentation as a means of tracking progress and working toward the elimination of restrictive interventions for participants served by the DOH/DDD.

Education and Training:
Providers must show documentation of agency personnel having training in the following: the participant's individual BSP; Positive behavioral supports introduction and overview; and nationally accredited crisis intervention system approved by DOH/DDD.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Information on any incidence of unauthorized restrictive interventions including restraints and seclusions are collected through the AER process. AER data unauthorized restrictive interventions, including analysis of trends and patterns are reported quarterly by the DOH/DDD Outcomes and Compliance Branch (OCB) to the BSRC, which completes a quarterly report and makes recommendations for quality improvement to the DOH/DDD Quality Assurance and Improvement Program (QAIP) Safety and Well-being Subcommittee of the QAIP Steering Committee Recommendations address programmatic, policy and/or systemic recommendations. BSRC, as a regularly reporter to through the QAIP process, and based on review of the data, develops performance measures related to the use of restraints as part of the QAIP Work Plan.

Issues related to provider agency performance are referred by the OCB or the BSRC to the DOH/DDD Provider Monitoring Section. If the issue requires an improvement plan or immediate corrective actions, the provider monitoring section requests, tracks and evaluates the implementation of improvement activities by the provider agency for effectiveness and addressing any core performance issues.

The BSRC reviews individual cases with the highest rates of unauthorized restrictive interventions including restraints and provides clinical recommendations. The BSRC will look at trends to assist in provider improvement and consultation with Training and Consultation to identify areas to address.

AER data on unauthorized restrictive interventions including restraints is gathered on an ongoing and continuous basis. The Branch Chief for the Outcomes and Compliance Branch receives all reports of serious issues, and can implement investigations, request information, or intervene immediately if serious violations of DOH/DDD's standards are detected. Aggregate data are analyzed and reported quarterly to the BSRC who reports to the Safety and Well-being Committee of the QAIP Steering Committee. The BSRC analyzes, reviews data and makes recommendations quarterly. Provider monitoring is conducted on a continuous monitoring basis, and site visits are conducted to each service site at least annually.

As part of the annual monitoring visit, the process includes a review of a sample of records to identify any events such as the use of restraints that were not reported as required. The provider must complete a corrective action plan (CAP) to address the participant-specific situation and revised policy, practice or other strategies the provider agency will employ to prevent further issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◎ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DOH/DDD P&P # 2.02 Restrictive Procedures prohibits the use of seclusion. DOH/DDD is responsible for detecting the unauthorized use of seclusions and any use of seclusion is required to be reported as an AER. Incidents that are seclusions are coded as such to put an emphasis on detection and oversight of this prohibited practice. Seclusion can also be detected in provider monitoring. The BSRC will review cases where seclusion is occurring and provide clinical recommendations on alternative methods to implement for the purpose of discontinuing the use of seclusion.

Seclusions are detected through the following methods:
A. All seclusions are reported through the Adverse Events Reporting (AER) system. All reports are monitored by the DOH/DDD for unauthorized use of seclusions require corrective action;
B. Routine quarterly monitoring by DOH/DDD case managers who are required to meet with the participant, review recent events and observe their interactions with staff and others;
C. The complaint and grievance process identifies any violation of rights or unauthorized use of seclusions;
D. Provider monitoring of performance occurs at least annually, and when any violations of standards are detected. Annual monitoring includes review of records, and direct discussions with Waiver participants;
E. On-site Certification Reviews of each adult foster home which is performed annually; and
F. Case review looking at a sample of cases to detect unauthorized use of seclusions by the DOH/DDD Clinical Intervention Team (CIT) who provides recommendations to case managers on alternative methods to prevent the use of seclusion.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For all individuals:

The DOH/DDD case manager, as part of their assessment/reassessment and monitoring responsibilities, reviews the individual's records in a certified or licensed setting when home visits are done. DOH/DDD policy is that the case managers are required to make at least one home visit annually.

For individuals receiving medications as part of waiver services, the service supervisor (registered professional nurse) is expected to comply with the Nurse Practice Act; quarterly service reports should include confirmation of medications administered. The DOH/DDD service supervisor will communicate with the Primary Care Provider (PCP), as necessary.

AERs identifying medication administration problems are submitted and reviewed by DOH/DDD and monitored by DHS. Follow up actions are made as necessary, including increased monitoring and/or training requirements.

The DOH/DDD Clinical Interdisciplinary Team (CIT) is available to discuss issues and concerns with medication issues, including polypharmacy, chemical restraints, etc. All cases identified as potentially at risk, e.g., polypharmacy, psychotropic usage, challenging behaviors, will be brought forth for discussion.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

a) For certified and licensed residential settings, the DOH/DDD certifying/licensing staff is responsible for the annual reviews to ensure that participant medications are managed appropriately by the certified/licensed caregiver. As part of the review, the certifying/licensing staff reviews the participant's home records, home operational practices regarding medications and health areas in terms of compliance with regulations, e.g., storage, physician's orders, administration, disposal of medications, including medical reports, medication errors, and medication administration flow sheets. If staff identifies any problems or concerns, follow up actions may include: a) informing the case manager of such concerns and requesting assistance with follow-up of participant's physician, guardian (if applicable), etc.; b) citation and requirement for plan of correction; c) referral for DOH/DDD follow up. The certifying/licensing staff will follow up on corrective actions taken (or not taken) and may pursue continued certification/licensure, probation, or termination of license or certificate.

b) AERs identifying those areas of potentially harmful practices are tracked to ascertain appropriate follow up action. This may include training, consultation sessions, sanctions, etc. Follow up of CIT reviews will also be done to ensure both appropriate follow up on individual situations and to identify system needs for training, consultation, or information sharing with community physicians.

c) Both DOH/DDD and DHS/MQD will collaborate on follow up and oversight. DHS/MQD is responsible for overseeing

that critical events are reported and satisfactorily addressed and resolved. The oversight includes a review of quarterly AERs summary reports submitted by DOH/DDD as well as a detailed review of any AER involving a death and AERs in participants and/or providers for which a trend has been identified. Both DOH/DDD reviews and DHS/MQD oversight together comprise aggregation and analysis of 100% of AERs received. DOH/DDD will work on remediation with waiver providers and DHS/MQD will work with DOH/DDD on remediation and system(s) change(s).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

◎ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver providers who administer medications as part of waiver services can only do so with a physician's order and by a registered nurse or as part of nurse delegation.

Medications
1) The following shall apply to medications ingested or administered during the hours the participant is in Waiver Program or Waiver Program services from a provider:
a) physician prescribed medications may be self-administered by a participant when the participant is physically and cognitively able to do so;
b) the participant may self-inject prescribed medications when the physician has written orders to permit this; and
c) the participant may be supported with medication administration when:
1) the medication has been pre-measured;
2) the medication is in individual doses;
3) the container is clearly labeled by the participant's caregiver, pharmacist, physician, RN or LPN with the participant's name and the time and route for the medication; and
4) the participant is able to take the single dose of medication independently. The provider staff assisting with the medication shall not place the medication in the participant's mouth.

2) Assistance with medication includes, but is not limited to, the following:
a) placing the labeled container with the pre-measured medication in the participant's hand;
b) assisting the participant with opening the container and dropping the medication into the participant's hand when needed;
c) instructing the participant to take the medication;
d) helping the participant to drink a liquid in order to swallow the medication;
e) watching and observing the participant to ensure that the medication has been swallowed; and
f) documenting the assistance with medication in the participant's chart.

3) The participant's record shall include the following information for each prescribed medication that the participant will take during the provider's service hours:
a) general information on recommended dosages and the medication's effect;
b) instructions for participant monitoring;
c) potential drug or food interactions; and
d) the provider shall follow the procedures for reporting Adverse Events (see provider Continuous Quality Assurance) observed by the provider, including medication errors and unexpected reactions to drugs or treatment, as specified in the standards.

iii. Medication Error Reporting. *Select one of the following:*

◎ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

All medication errors must be reported as an adverse event report. Such reports are sent to DOH/DDD for review.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors – missing a dose, giving a wrong dose at the wrong time or to the wrong individual, not complying with physician's orders, adverse reactions to medications (over the counter and prescribed), unexpected reactions to drugs or treatment - must be reported as an adverse report. Such reports are sent to DOH/DDD for review.

(c) Specify the types of medication errors that providers must *report* to the State:

All medication errors and unexpected reactions to drugs or treatment.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

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iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DOH/DDD staff review reports of medication errors and follow up as necessary on corrective action. Medication errors and unexpected reactions to drugs or treatment by the provider agencies are reported using the AER form. Data is collected and summarized to identify trends, remediation, and opportunities for system improvement, such as additional training for provider or a medical assessment for the participant or a change in DOH/DDD policy. DHS/MQD receives and reviews a summary of the AER reports quarterly.

Providers submit medication errors on an AER form. Copies of all adverse events reports are submitted to DOH/DDD for review. The reports are logged into the DOH/DDD database, tracked, and trended. Remediation activities are identified and followed-up as a result of each AER. DOH/DDD follows guidelines that are issued by DHS/MQD and follows established policies and procedures.

DHS/MQD is responsible for overseeing that all adverse events, including all medication errors, are reported and are satisfactorily addressed and resolved. An overview of this oversight includes:

1) review of quarterly AER Summary Reports submitted by DOH/DDD, which will comprise of an aggregation and analysis of 100% of AERs received. DHS/MQD will notify DOH/DDD if further remediation, corrective action, or system improvement is needed;
2) detailed review of AER Reports for all deaths; and
3) detailed review of AER Reports for participants or providers that raise concerns based on monitoring trends.

All waiver providers are required to have an Internal Quality Improvement program that includes a process that provides for ongoing monitoring, quarterly assessment and trending of Adverse Events for appropriateness of action taken, follow-up and preventive actions to be taken.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of adverse event reports (AERs): By provider; participant; and type. N: # of adverse event reports (AERs): By provider; participant; and type. D: Total # of AERs submitted

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER summary report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☐ **Continuously and Ongoing**
☐ **Other** Specify:

Performance Measure:
#/% of AERs with an appropriate immediate action by provider agency/CDPA/caregiver of licensed or certified home to safeguard participant as assessed by the DOH/DDD case manager. N: # of AERs with an appropriate immediate action by provider agency/CDPA/caregiver of licensed or certified home to safeguard participant as assessed by the DOH/DDD case manager D: Total # of applicable AERs

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER Summary Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of deaths that required follow-up for which follow-up was completed. N: # of deaths that required follow-up for which follow-up was completed D: # of deaths that required follow- up as determined by the DDD Mortality Review Committee

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER Summary Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% Number and percent of AERs initiated by the provider agency/CDPA and reported within required time frame (Verbal report DOH/DD CM within 24 hours, Written report to DOH/DDDCM within 72 hours) N: # of AERs initiated by the provider agency/ CDPA reported within required time frame D: Total # of applicable AERs submitted

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER Summary Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
#/% of AERs with an appropriate plan of action, by the provider agency/CDPA/caregiver of licensed or certified home to prevent recurrence of adverse event as assessed by case manager
N: # of AERs with an appropriate plan of action by the provider agency/CDPA/caregiver of licensed or certified home to prevent recurrence of adverse event as assessed by case manager
D: Total # of applicable AERs

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER Summary Report

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of prohibited restrictive interventions that resulted in an AER N: # of prohibited restrictive interventions that resulted in an AER in accordance with policies and procedures D: all prohibited restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER Summary Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval

		=
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: sample of records by monitoring team looking for restrictive interventions that should have been reported but weren't
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of deaths that required follow-up for which follow-up was completed. N: # of deaths that required follow-up for which follow-up was completed D: Total # of deaths that required follow-up

Data Source (Select one):
Other
If 'Other' is selected, specify:
AER Summary Report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOH/DDD is responsible for reviewing all adverse or critical event reports and ensuring that each adverse event is addressed and resolved appropriately. If remediation is needed, DOH/DDD confirms the completion and documentation of the remediation activities. For service provider agencies, remediation activities may include re-training of its staff and increasing the frequency of on-site quality reviews by DOH/DDD.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the

services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DHS/MQD Quality Strategy was approved by CMS in State Fiscal Year 2011. It is a comprehensive strategy that includes the monitoring of Home and Community-Based Services and is the framework for monitoring of the waiver. The strategy describes implementation of a Quality Flow Process, which ensures reviewing of monitoring reports followed by immediate remediation, trending, prioritizing, and implementing system changes.

DHS/MQD receives and reviews all quarterly monitoring and quality reports from the DOH/DDD. Standardized reporting and review tools have been developed to allow for improved oversight and trending over time. Findings from the reports will be presented to the Quality Strategy Committee as the reports are received and reviewed according to a monitoring calendar. The Committee is comprised of representatives from the Quality Strategy Leadership Team, technical experts for the waiver, and the reviewer(s). The committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committee will recommend feedback to the DOH/DDD, and corrective action will be requested if needed. Findings and recommendations will be properly documented. The Leadership Team will also meet quarterly to review the findings and recommendations from the Committee, analyze trends, and set priorities, focusing on critical and high impact issues requiring system(s) change(s) that relate to meeting established goals and objectives. At least semi-annually and as needed, the Leadership Team will meet collaboratively with DOH/DDD. These Quality Collaboratives will allow opportunity of dialogue, feedback, follow-up of corrective actions, exchange of information, and identification of best practices.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DHS/MQD
A Quality Strategy Leadership Team meets regularly to review the findings and recommendations from Quality Strategy Committees. The Leadership Team will also meet collaboratively with DOH/DDD on a regular basis to allow for dialogue, feedback, and follow-up of corrective actions, performance improvement projects, exchange of information, and identification of best practices. System improvements will be identified and monitored as a result of these collaborative reviews of monitoring trends, results of remediation, and best practices. The following shows a summary of the Quality Strategy Oversight.

Summary of the Quality Strategy Oversight (entities, membership and responsibilities):

Entity: Quality Strategy Leadership Team (QSLT)
Membership:
- DHS/MQD leadership from several branches and offices;
- DHS/MQD Medical Director or Physician Designee; and
- External Quality Review Organization (EQRO) consultant as needed.
Responsibilities:
- lead the development, review, and revision of Quality Strategy;
- oversight for review of quality data and monitoring reports;
- oversight for quality improvement recommendations and implementation of these recommendations by the waiver program;

- meets quarterly and more often as needed; and
- meets semi-annually in Collaboratives with the waiver program.

Entity: Quality Strategy Committees (QSC)
Membership:
- QSLT representative;
- DHS/MQD technical expert(s) in the waiver; and
- DHS/MQD HCBS reviewer(s)
Responsibilities:
- committees include the waiver committee;
- review of quality data and monitoring reports from the waiver program;
- recommendations for corrective actions, quality improvement, and system changes;
- follow-up of corrective actions and quality improvement recommendations; and
- meets in a monthly rotation.

Entity: Quality Collaboratives
Membership:
- QSLT representative(s);
- DHS/MQD technical expert(s);
- DOH/DDD Waiver program representative(s); and
- EQRO consultant if needed.
Responsibilities:
- serves as forum between DHS/MQD and the waiver program for dialogue, feedback, follow-up of corrective action, performance improvement projects (PIPs), and best practices; and

- meets semi-annually.

DOH/DDD
DOH/DDD has implemented a Quality Assurance and Improvement Program (QAIP) to ensure the systematic monitoring of all services and supporting service infrastructure. It has a formal program description, work plan with performance measures, and a committee structure. The QAIP Steering Committee oversees the implementation of the QAIP and is chaired by the DOH/DDD Medical Director. Three subcommittees meet on a quarterly basis to receive and review reports and data: the Quality Services and Care Subcommittee, the Utilization/System Integration Review Subcommittee, and the Safety and Well-being Subcommittee. Key committees operate under the Subcommittee structure, including the Mortality Review Committee that reviews deaths of every participant, and reports to the Safety and Well-being Subcommittee, The QAIP is evaluated and revised on an annual basis, with annual goals and objectives. The DOH/DDD Management Team provides approval of recommendations from the QAIP Steering Committee and can assign Improvement Teams to design programmatic quality improvements. DOH/DDD also operates several standing committees including the Utilization Review Committee (URC) that reviews appropriate use of services and makes recommendations for adjustment, approval, or denial of services, and the Clinical Interdisciplinary Team (CIT) that reviews and makes recommendations regarding clinical issues.

DOH/DDD, with representation from DHS/MQD, conducts regular quarterly meetings with the Waiver Policy Advisory Committee (PAC). This group includes participants, families, providers, DD Council, Hawaii Disability Rights Coalition, the Center for Disability Studies at the University of Hawaii-Manoa and DOH/DDD staff. Any changes to the waiver, including changes related to quality monitoring, are discussed in these stakeholder meetings. In addition, DHS/MQD maintains a website that will hold information about the waiver program, including performance on quality monitoring.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Strategy is a dynamic system, which both DHS/MQD and DOH/DDD continual review to assess the effectiveness of the waiver monitoring. The Quality Strategy, including DOH/DDD monitoring, will be reviewed at least annually by the Quality Strategy Leadership Team and revised, if necessary. However, the Quality Strategy Committees may suggest changes to the Leadership Team throughout the year that will be reviewed to identify whether a suggested change necessitates a review and revision of the Quality Strategy sooner than the appointed time. At each review and revision of the strategy, the Leadership Team will determine whether the changes made to the Quality Strategy are significant enough to require additional stakeholder input and a public comment period. Significant changes are changes that may impact quality activities and/or threaten the potential effectiveness of the Quality Strategy. At least once every five (5) years, unless significant changes dictate a sooner timeframe, a 30-day public comment period will be made available.

The Quality Strategy is reviewed with criteria such as: a) ongoing validity of data; b) extent to which the discovery data is actionable; c) efficiency of data collection; d) utility and frequency of monitoring reports; e) utility of remediation efforts; and f) need for addition of other measures and data gathering methods based on identified trends and priorities.

The Quality Strategy is also reviewed to ensure that system(s) change(s), e.g. policy changes, training, technical assistance, etc. are effective. The Quality Committees and Leadership Team will regularly review and assess system(s) change(s) to ensure implementation and effectiveness in the light of measurement trends. DHS/MQD and DOH/DDD discuss the implementation and effectiveness of system(s) change(s) in regular Collaborative meetings.

A Work Plan is written annually to supplement the Quality Strategy during the annual review and revision process. Part of the Work Plan includes a specific section on any revisions to waiver monitoring. The development of the Work Plan specific to waiver monitoring begins with an assessment of accomplishments and challenges from the previous year's Work Plan and summary analyses/input from the Quality Strategy Committee's review of monitoring reports. The Work Plan development also incorporates input from other sources such as the DOH/DDD, the Waiver PAC, the managed care health plans, participants, providers, partner government agencies, and stakeholders. The Work Plan will clearly document the effectiveness of the Quality Strategy by summarizing successes and challenges as well as interim performance results. The Work Plan also outlines areas of focus for quality activities, such as quality improvement measures, improvement projects, and performance indicators.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) Provider agencies that bill for services in excess of $500,000 shall be responsible to procure an annual end-of-the year audit conducted by an independent CPA.

b) The DOH/DDD Fiscal Office reviews all waiver providers at least annually using on-site reviews and desk audits of records. For each provider, the DOH/DDD Fiscal Office selects a statistically valid random sample of the participants served during a one-year period. For the participants selected for review, the DOH/DDD Fiscal Office reviews the ISP to ensure the services were authorized (service level and number of units) and compares the paid claims information (from HPMMIS, the Medicaid MMIS) against the authorized services. The DOH/DDD Fiscal office verifies that the service code and units billed and payment match the authorizations. The DOH/DDD Fiscal Office verifies timesheets signed by the provider of services, reviews attendance logs and examines other records, as appropriate, to ensure the documentation supports the claim billed by the provider. If necessary, the DOH/DDD Fiscal Office may contact the participant or his/her representative to verify the delivery of services by the provider agency.

c) DHS/MQD delegates the financial reviews to the DOH/DDD and provides oversight of delegated responsibilities through review of quarterly monitoring reports. The DOH/DDD submits a report detailing the findings of each provider review to DHS/MQD. Any cases requiring remediation and/or follow-up action will be handled by the DOH/DDD. In addition, the DHS/MQD validates a sample of DOH/DDD provider on-site reviews at least annually.

Every provider that receives $500,000 or more in Medicaid funds during a year is required by the Waiver Standards to perform an independent financial audit by a CPA agency and submit the audit to the State for review. If inconsistencies are noted, the State will request additional information. In addition to the independent audit, the DOH/DDD fiscal office staff who are accountants conducts annual audits of a sample of records following a procedure similar to the PERM audit and will recoup Medicaid funds paid without proper supporting documentation. The State had its PERM audit last year and of all DD waiver provider records sampled, only one claim was found to be out-of-compliance, which is an extremely high rate of accuracy.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of waiver participants who received services that were authorized and payment for those services is supported by the appropriate documentation N: # of waiver participants who received services that were authorized and payment for those services is supported by the appropriate documentation D: Total # of participant reviewed in the quarter

Data Source (Select one):
Other
If 'Other' is selected, specify:
DOH/DDD Fiscal Section Audit

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
#/% of payments made that are consistent with the established rate methodology. N: # of claims that were paid the appropriate rate D: Total # of payments

Data Source (Select one):
Other
If 'Other' is selected, specify:
XEROX report

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHS/MQD identifies individual problems through quarterly reports received from its fiscal agent and DOH/DDD. For claims not paid in a timely manner, technical assistance is provided to the fiscal agent to improve timely processing of claims. For a claim paid with a cost share error or for a suspended participant, remediation is specific to the problem, i.e. incorrect suspension dates inputted or cost share information not provided and payment is recouped. In addition, DHS shall provide training to DOH/DDD as needed to assure that financial processes are managed correctly.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate determination and oversight is a joint responsibility between the Department of Health's Division of Developmental Disabilities (DDD) and the Department of Human Services' Med-QUEST Division.

Most waiver services are reimbursed on a prospective, fee-for-service basis, with the exceptions noted below for items and services that are procured and manually priced. The current rates incorporated in this waiver were calculated based on a rate analysis completed a number of years ago for past waivers that considered the mean (average) direct care staff wages reported by providers, a standard employee benefit rate to cover payroll taxes and other benefits, and an agency administration and program support rate

based on the mean (average) reported on providers' financial statements.

DDD is presently engaged in a comprehensive study of waiver rates that will be completed in the second half of calendar year 2016. DDD has engaged Burns & Associates, Inc., a national consultant experienced in developing provider reimbursement rates for HCBS waivers, to provide technical assistance in this study. The State has identified several revised and new services that will enhance participants' supports for full community integration. The State will submit an amendment to CMS upon completion of the rate study to adjust the rates based on the rate study data.

The following are new services that have "placeholder" projections based on available utilization data, or projections based on increased utilization over time of these services that support better access to community integration, and decreased utilization of services that support less access to community life:

Residential Habilitation – Implement with waiver approval; this service was previously in the current waiver, ended during the 2011-2016 waiver and returning to the service array in SFY2017 (Waiver Year 1). In Appendix J, the projections are based on historical data from 372s based on utilization in prior waiver years, and PAB services thus reduced to reflect the shift from PAB back to Residential Habilitation.

Discovery & Career Planning –is a revised service that replaces the current Prevocational Service. The utilization and average cost/unit is based on historical data from 372 reports for Prevocational Services pending the completion of the rate study.

The rate study will include:
- A series of meetings with a Provider Advisory Group. The group is comprised of a diverse cross-section of providers in terms of services delivered, size, and location. The group will be convened at key milestones in the study, including development of a draft provider survey, consideration of survey results, and a presentation of proposed rate models. The first meeting of the Provider Advisory Group has already been held in March 2016.

- Inviting all providers to complete a survey related to their service design and costs.

-Identification of benchmark data, including Bureau of Labor Statistics cross-industry wage and benefit data as well as rates for comparable services in similar programs.

- Development of rate models that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration. The rate models will include the State's minimum wage increases pursuant to the Hawaii Wage and Labor Law (Chapter 387, Hawaii Revised Statutes and Chapter 12-20, Hawaii Administrative Rules).

- Incorporating Supports Intensity Scale assessment data to create 'tiered' rates for Personal Assistance/Habilitation, Residential Habilitation and Adult Day Health services to recognize the need for more intensive staffing for individuals with more significant needs.

- An 'informal' public comment process through which proposed rate models will be emailed to providers and other stakeholders, and posted online. Interested parties will be given several weeks to submit written comments. DDD will prepare written responses to all comments received and revise the rates as appropriate. In addition to this informal process, a formal 30-day public notice and comment period and formal tribal notice will be completed prior to submitting a waiver amendment to CMS that incorporates the final rates and rate methodologies.

Rate models will be developed for all waiver services with a few exceptions. Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Vehicular Modifications, and Assistive Technology services are reimbursed through manual pricing, up to the limits specified in the service description.

The waiver rate schedule will be available on DDD's website.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All services, regardless of payment processing, are prior authorized by the DOH/DDD case managers.

1) Agency Provided Services
All waiver services are prior authorized by the DOH/DDD case managers and forwarded to the DHS/MQD fiscal agent. Waiver agency providers' claims processing/payment follows the State's Medicaid Fee-For-Service process. The DHS/MQD Fiscal Agent enters the prior authorizations into HPMMIS, the State's MMIS. Providers render the services and send their claims for the services to the DHS/MQD Fiscal Agent for processing. Providers have the option of submitting claims electronically or manually on a CMS 1500 form. The DHS/MQD Fiscal Agent provides an electronic HIPAA-compliant interface that enables providers to send claims electronically. If the providers want to file manual claims, the claims are sent to the DHS/MQD Fiscal Agent's office located on Oahu for processing. HPMMIS adjudicates claims on a daily basis and processes payments on a weekly basis. Prior to the checks being generated, the DHS/MQD Fiscal Agent will notify DHS/MQD of the funds required for the week's payment. DHS/MQD bills DOH/DDD for the required State funds portion on a weekly waiver basis. Checks are generated at the end of each week. Providers

have the option of receiving their payment electronically (deposited directly into the provider's bank account) or by mail. Providers also have the option to receive their remittance advices electronically or by mail with the check.

2) Consumer Directed-Personal Assistance Option
The DHS/MQD limited fiscal agent performs payroll processing functions to pay claims for consumer directed personal assistance services. The invoice for the participant's employee's hours or days worked for the previous month is received by DOH/DDD. Following a review of the invoice, the information is inputted electronically to the limited fiscal agent for payroll processing. The limited fiscal agent sends a summary of the consumer directed personal assistance payments to the DHS/MQD Finance Office, which creates a bill of collection that is sent to DOH/DDD for payment of the state portion (non-federal share).

3) Environmental Accessibility Adaptations, Specialized Medical Equipment & Supplies that require unique pricing; Vehicular Modifications, Assistive Technology,
Following the delivery of service, providers submit invoices to and are paid by DOH/DDD. The invoices are processed following the State of Hawaii Department of Accounting and General Services (DAGS) policies and procedures to generate a state purchase order. Quarterly, a file containing all the items paid for by DOH/DDD is submitted to DHS/MQD for Medicaid eligible waiver participants. Upon receipt, DHS/MQD sends a bill of collection to DOH/DDD for the state portion (non-federal share). DOH/DDD will then voucher the state share to DHS/MQD. DHS/DDD will pay DOH/MQD the total invoice at a later date. Subsequently, DHS/MQD will draw down the federal share from CMS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

◎ **No. State or local government agencies do not certify expenditures for waiver services.**

Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All services are identified in the participant's individual service plan; the DOH/DDD case manager prior authorizes before services are delivered and enter the authorized services into a calculator that is uploaded to reference table (procedure codes, modifiers, and

payment rates) to the DHS/MQD fiscal agent.

a) Edits are in place to ensure that claims for payment are made only when the participant is eligible for Medicaid waiver payment on the date of service. The following describes the different claim methodologies.

1) Agency Provided Services
The DHS/MQD fiscal agent processes all provider agency claims. HPMMIS contains individual Medicaid eligibility information, reference tables of approved waiver services, (procedure codes, modifiers and payment rates), prior authorizations, and qualified provider information. All claims are adjudicated according to edit checks, e.g., participant is Medicaid eligible and "enrolled" in the waiver at the time of service. Based on system rules, HPMMIS denies claims that fail the edit checks, e.g., claim for a participant not Medicaid eligible on the date of service. HPMMIS generates paid claims reports to validate the claims for Federal reimbursement.

2) Consumer Directed-Personal Assistance option
These claims are paid outside of the HPMMIS system. DOH/DDD validates Medicaid eligibility on the date of service, reviews that the units of services are within the authorized amount in the participant's ISP, assures provider certification requirements are met and enters all information necessary to authorize payment directly into the contracted limited fiscal agent's electronic payroll system. DOH/DDD reviews and transmits the information to the limited fiscal agent for this payroll processing. This limited fiscal agent generates the summary of the consumer directed payments and the participant's checks for delivery to DOH/DDD for mailing to the participants. Submittal of the bill of collection is then routed to DOH/DDD for remuneration of the non-federal share of the payments.

3) Environmental Accessibility Adaptations, Specialized Medical Equipment & Supplies, Vehicular Modifications, Assistive Technology
These claims are paid through purchase orders processed by the DHS/MQD Fiscal Office. Following the delivery of the service, the vendor invoice is sent to the DOH/DDD case manager to confirm the service was delivered, verify that the participant was Medicaid eligible on the date of service, the service was prior authorized, the billed amount is within the authorized amount and the provider is certified and/or licensed to provide services. If the invoice is approved, the DOH/DDD case manager submits the invoice for payment to the DOH/DDD Fiscal Office. The DOH/DDD Fiscal Office prepares a purchase order and processes the invoice for payment compliant with the DAGS policies and procedures. DAGS mails the check to the vendor.

b) Edits are in place to ensure that claims for payment are made only when the service was included in the participant's approved service plan through a check against the prior authorization in the system, including service dates within the authorization period and using valid (the prior authorized code) procedure codes. Claims are priced using the rates in HPMMIS. If there is no prior authorization, the claim will be denied.

c) The annual claims audit performed by the DOH/DDD Fiscal Section staff is used to verify that the billed services were actually authorized in the service plan, provided by the provider, employee or vendor. If the DOH/DDD Fiscal staff identifies unsubstantiated or erroneous billings, the DOH/DDD Fiscal Office sends a formal letter to the provider, employee or vendor seeking recovery of the overpayment. In the case of claims, the DHS/MQD fiscal agent is able to adjust the claim and recoup the overpayment. In the case of payroll and invoices, the employee/vendor must return a check for the overpayment to the DOH/DDD Fiscal Office.

The DOH/DDD Fiscal Office maintains a log of money collected and submits to the DHS/MQD Finance Office on a quarterly basis to ensure proper crediting back to the federal government.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

◎ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a) The only waiver services that are not paid through an approved MMIS are environmental accessibility adaptations, certain specialized equipment that require unique pricing, vehicular modification, assistive technology, and consumer directed services.

b) & c) Environmental accessibility adaption, certain medical equipment requiring unique pricing, vehicular modification, and

assistive technology:

Payment for these items is made by the DOH/DDD with 100% State funds. DOH/DDD sends copies of the purchase order and payment to DHS to support the federal FFP reimbursement. After verifying the payment, DHS/MQD transfers the FFP to DOH/DDD. The following identifies the steps taken to substantiate payment:

1) The DOH/DDD case manager authorizes services in the participant's services plan, sends hard copy notifications to authorized provider for service type to be rendered with the participant's specific information.

2) After rendering the services, the provider submits an invoice for payment to the DOH/DDD case manager who confirms that the participant was Medicaid eligible at the time the work was performed or service delivered, and the invoice is within the prior authorized amount. If the invoice can be paid, the case manager authorizes the invoice for payment and sends the invoice to the DOH/DDD Fiscal Office.

3) The DOH/DDD fiscal staff processes the invoice for payment following the authorized DAGS policies and procedures. DAGS will prepare and mail the check directly to the provider.

4) The DOH/DDD fiscal staff generates a summary worksheet on a quarterly basis and submits it to DHS/MQD. The supporting documents (service authorization, invoice and purchase order) as proof of payment with 100% State funds are maintained with the DOH/DDD fiscal office and are available for DHS to review if necessary.

5) DOH/DDD reviews the summary worksheet prior to sending it to DHS/MQD to ensure there are no duplicate invoices.

6) DHS/MQD will send DOH/DDD a Bill of Collection for the non-federal portion for all transactions for the above-named services. DOH/DDD will voucher over the non-federal portion for all transaction for the above-named services. DOH/DDD will voucher over the non-federal share to DHS/MQD.

7) Payment to DOH/DDD is based on submission of a Bill of Collection by services which is based on the quarterly summary submitted by DOH/DDD as follows: a) reimbursement shall be allowed on invoices deemed payable; b) reimbursement shall be journal vouchered to DOH/DDD based on normal State fiscal timelines; c) reimbursement shall be determined on the fee that is notated on the paid invoices per supporting documentation submitted with the Bill of Collection.

8) Any services or work denied by DHS/MQD are returned to DOH/DDD for resolution.

9) A spreadsheet reflecting the paid invoices is attached to processed journal voucher and returned to DOH/DDD along with the original DOH/DDD worksheet for reconciliation purposes.

Consumer Directed (CD) Waiver Services: The DOH/DDD transfers the state match for CD services to DHS/MQD which transfers the FFP to DOH/DDD. The following identifies the steps taken to substantiate payment:

1) DOH/DDD case manager authorizes services in the participant's service plan and notifies the DOH/DDD CD specialist.

2) DOH/DDD specialist processes necessary payroll paperwork with the participant and sends the paperwork to the appropriate fiscal agent. DOH/DDD specialist coordinates meeting/training to participant/designated representative.

3) DOH/DDD specialist reviews all vouchers submitted by CD services participants to ensure the participant is Medicaid eligible and the services have been authorized.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DDHS/MQD through a contract with a limited fiscal agent pays for waiver services that use the Consumer Directed Option. The limited fiscal agent performs general payroll functions on behalf of the participants' employees.

The limited fiscal agent's services are primarily payroll activities such as withholding of applicable taxes. The limited fiscal agent, at direction of DOH/DDD, generates special deduction checks (levies, child support, etc.). Oversight activities include the review of system summary reports as described in Appendix E and other quality activities conducted by DHS/MQD staff. DOH/DDD staff enters employee service data directly into the limited fiscal agent's system for processing of paychecks on the participant/employer's behalf. The DOH/DDD staff assures that human errors are kept at a minimum by conducting reviews at various stages: hours worked are verified against authorizations, check amount is validated, etc.

The DOH/DDD Fiscal Office submits a Bill of Collection to DHS/MQD for the State portion of the total payments made for the CD option. The charged amount is verified by a Summary Warrant Voucher report. The amount that is paid each month is recorded on the voucher log maintained by DHS/MQD and included in the CMS 64 report for each quarter.

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (o) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◎ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◎ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

◎ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

◎ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

◎ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or

agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

a) DOH/DDD
b) Funds are directly expended by DOH as IGTs for Environmental Accessibility Adaptation, Specialized Medical Equipment & Supplies, Vehicular Modifications, Assistive Technology, and Personal Emergency Response System. DHS/MQD transfer FFP for all other waiver services processed through the fiscal agents.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

Applicable
Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

The following source(s) are used
Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

SSI payments are used for room and board costs in adult foster homes, DD domiciliary homes, adult residential care homes, and expanded adult residential care homes.

All services rates that are billed by providers exclude room and board costs. The fiscal agent will only pay the rates that are loaded into HPMMIS and cannot override the rates to allow for any room or board costs.

When a participant receives respite, the participant's pro-rated SSI room and board costs that are normally paid by the participant to the routine caregiver are paid to the respite caregiver.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject

to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	38063.97	5649.62	43713.59	119424.79	4398.69	123823.48	80109.89
2	38056.01	5773.91	43829.92	122052.13	4495.46	126547.59	82717.67
3	38064.32	5900.93	43965.25	124737.28	4594.36	129331.64	85366.39
4	38076.21	6030.75	44106.96	127481.50	4695.44	132176.94	88069.98
5	38063.92	6163.43	44227.35	130286.09	4798.73	135084.82	90857.47

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	2735	2735
Year 2	2767	2767
Year 3	2799	2799
Year 4	2831	2831
Year 5	2863	2863

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay of 355 days is based on WY4 2014-2015 length of stay.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimates regarding the number of users and units per user were derived from an analysis of paid claims with start or end dates of services in state fiscal year 2015 (July 1, 2014 through June 30, 2015). The estimates generally assume the ratio of enrollees to users is constant for each service. So, each percentage increase in total enrollment leads to the same percentage increase in the number of users of a service. The number of units per user is assumed to remain constant the State does not anticipate changes in utilization patterns.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' projections are based on actual costs for WY4 2014-2015 ($5,430) then increased by 1.8% for WY5 and 2.2% each year of the waiver renewal, based on the CMS nursing home withour Capital market Basket utilized by DHS/MQD to calculate the inflation factor for Hawaii PPS Rates. The state's estimate of D' costs does not include prescribed drugs for dual eligibles. Hawaii does not pay for any prescription drugs, including the copays for dual eligible members.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G projections are based on actual costs for WY4 2014-2015 ($114,788) then increased by 1.8% for WY5 and 2.2% each year of the waiver renewal, based on the CMS nursing home withour Capital market Basket utilized by DHS/MQD to calculate the inflation factor for Hawaii PPS Rates.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' projections are based on actual costs for WY4 2014-2015 ($4,228) then increased by 1.8% for WY5 and 2.2% each year of the waiver renewal, based on the CMS nursing home withour Capital market Basket utilized by DHS/MQD to calculate the inflation factor for Hawaii PPS Rates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Health (ADH)
Discovery & Career Planning (DCP)
Individual Employment Supports
Personal Assistance/Habilitation (PAB)
Residential Habilitation (ResHab)
Respite
Skilled Nursing
Assistive Technology
Chore
Environmental Accessibility Adaptations
Non-Medical Transportation
Personal Emergency Response System (PERS)
Specialized Medical Equipment and Supplies
Training and Consultation
Vehicular Modifications
Waiver Emergency Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per

User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health (ADH) Total:						**22343936.24**
Adult Day Health Level 1	Day	1042	185.20	66.56	**12844642.30**	
Adult Day Health Level 2	Day	468	209.20	83.01	**8127143.86**	
Adult Day Health Level 3	Day	58	201.60	117.35	**1372150.08**	
Discovery & Career Planning (DCP) Total:						**359573.10**
Discovery & Career Planning (DCP)	Hour	30	378.10	31.70	**359573.10**	
Individual Employment Supports Total:						**107546.16**
Individual Employment Supports	15 min/unit	11	741.80	13.18	**107546.16**	
Personal Assistance/Habilitation (PAB) Total:						**55642673.00**
Personal Assistance/Habilitation Level 1	15 min/unit	1677	2542.60	6.23	**26564347.45**	
Personal Assistance/Habilitation Level 2	15 min/unit	621	4602.40	7.60	**21721487.04**	
Personal Assistance/Habilitation Level 3	15 min/unit	6	6071.40	7.53	**274305.85**	
CD Personal Assistance/Habilitation Level 1	15 min/unit	428	3985.20	2.95	**5031713.52**	
CD Personal Assistance/Habilitation Level 2	15 min/unit	113	4958.70	3.66	**2050819.15**	
Residential Habilitation (ResHab) Total:						**18851007.00**
Residential Habilitation (ResHab)	Day	713	350.00	75.54	**18851007.00**	
Respite Total:						**3005018.50**
Respite Unit	15 min/unit	69	1550.20	3.89	**416089.18**	
Respite Daily	Day	96	76.80	127.40	**939294.72**	
Respite Consumer Directed Unit	15 min/unit	197	1418.00	2.60	**726299.60**	
Respite Consumer Directed Daily	Day	175	37.00	142.60	**923335.00**	
Skilled Nursing Total:						**2708390.66**
Skilled Nursing RN	15 min/unit	126	3417.20	4.65	**2002137.48**	
Skilled Nursing LPN	15 min/unit	48	4042.20	3.64	**706253.18**	
Assistive Technology Total:						**25000.00**
Assistive Technology	Item	5	5.00	1000.00	**25000.00**	
Chore Total:						**280460.86**
Chore Unit	15 min/unit	27	2584.70	3.23	**225411.69**	
Chore Consumer Directed Unit	15 min/unit	19	1287.70	2.25	**55049.18**	
Environmental Accessibility Adaptations Total:						**80000.00**

Environmental Accessibility Adaptations	Service	2	1.00	40000.00	80000.00	
Non-Medical Transportation Total:						87543.63
Transportation Mile	Mile	13	2976.90	1.89	73142.43	
Transportation Trips	Trip	33	218.20	2.00	14401.20	
Personal Emergency Response System (PERS) Total:						2077.41
Personal Emergency Response System (PERS) Service	Service	1	3.00	21.67	65.01	
Personal Emergency Response System (PERS) Monthly	Month	6	7.80	43.00	2012.40	
Specialized Medical Equipment and Supplies Total:						1174.00
Specialized Medical Equipment and Supplies	Item	2	1.00	587.00	1174.00	
Training and Consultation Total:						296639.95
Training and Consultation	Hour	84	44.60	79.18	296639.95	
Vehicular Modifications Total:						50000.00
Vehicular Modifications	Service	2	1.00	25000.00	50000.00	
Waiver Emergency Services Total:						263915.31
Emergency Shelter	Day	10	53.60	475.71	254980.56	
Emergency Outreach	Day	33	3.80	71.25	8934.75	
				GRAND TOTAL:		104104955.84
				Total Estimated Unduplicated Participants:		2735
				Factor D (Divide total by number of participants):		38063.97
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health (ADH) Total:						22602345.40
Adult Day Health Level 1	Day	1054	185.20	66.56	12992565.25	
Adult Day Health Level 2	Day	473	209.20	83.01	8213972.32	
Adult Day Health Level 3	Day	59	201.60	117.35	1395807.84	
Discovery & Career Planning (DCP) Total:						359573.10
Discovery & Career Planning (DCP)	Hour	30	378.10	31.70	359573.10	
Individual Employment Supports Total:						117323.09

Individual Employment Supports	15 min/unit	12	741.80	13.18	117323.09	
Personal Assistance/Habilitation (PAB) Total:						56281259.19
Personal Assistance/Habilitation Level 1	15 min/unit	1697	2542.60	6.23	26881155.41	
Personal Assistance/Habilitation Level 2	15 min/unit	628	4602.40	7.60	21966334.72	
Personal Assistance/Habilitation Level 3	15 min/unit	6	6071.40	7.53	274305.85	
CD Personal Assistance/Habilitation Level 1	15 min/unit	433	3985.20	2.95	5090495.22	
CD Personal Assistance/Habilitation Level 2	15 min/unit	114	4958.70	3.66	2068967.99	
Residential Habilitation (ResHab) Total:						19062519.00
Residential Habilitation (ResHab)	Day	721	350.00	75.54	19062519.00	
Respite Total:						3038759.10
Respite Unit	15 min/unit	70	1550.20	3.89	422119.46	
Respite Daily	Day	97	76.80	127.40	949079.04	
Respite Consumer Directed Unit	15 min/unit	199	1418.00	2.60	733673.20	
Respite Consumer Directed Daily	Day	177	37.00	142.60	933887.40	
Skilled Nursing Total:						2740170.62
Skilled Nursing RN	15 min/unit	128	3417.20	4.65	2033917.44	
Skilled Nursing LPN	15 min/unit	48	4042.20	3.64	706253.18	
Assistive Technology Total:						25000.00
Assistive Technology	Item	5	5.00	1000.00	25000.00	
Chore Total:						280460.86
Chore Unit	15 min/unit	27	2584.70	3.23	225411.69	
Chore Consumer Directed Unit	15 min/unit	19	1287.70	2.25	55049.18	
Environmental Accessibility Adaptations Total:						80000.00
Environmental Accessibility Adaptations	Service	2	1.00	40000.00	80000.00	
Non-Medical Transportation Total:						93606.37
Transportation Mile	Mile	14	2976.90	1.89	78768.77	
Transportation Trips	Trip	34	218.20	2.00	14837.60	
Personal Emergency Response System (PERS) Total:						3487.04
Personal Emergency Response System (PERS) Service	Service	1	21.67	68.05	1474.64	
Personal Emergency Response System (PERS) Monthly	Month	6	7.80	43.00	2012.40	
Specialized Medical Equipment and Supplies Total:						1174.00
Specialized Medical Equipment and Supplies	Item	2	1.00	587.00	1174.00	
Training and Consultation Total:						300171.38
Training and Consultation	Hour	85	44.60	79.18	300171.38	

Vehicular Modifications Total:						**50000.00**
Vehicular Modifications	Service	2	1.00	25000.00	**50000.00**	
Waiver Emergency Services Total:						**265137.48**
Emergency Shelter	Day	10	53.80	475.71	**255931.98**	
Emergency Outreach	Day	34	3.80	71.25	**9205.50**	
		GRAND TOTAL:				**105300986.64**
		Total Estimated Unduplicated Participants:				**2767**
		Factor D (Divide total by number of participants):				**38056.01**
		Average Length of Stay on the Waiver:				355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health (ADH) Total:						**22854462.50**
Adult Day Health Level 1	Day	1066	185.20	66.56	**13140488.19**	
Adult Day Health Level 2	Day	479	209.20	83.01	**8318166.47**	
Adult Day Health Level 3	Day	59	201.60	117.35	**1395807.84**	
Discovery & Career Planning (DCP) Total:						**371558.87**
Discovery & Career Planning (DCP)	Hour	31	378.10	31.70	**371558.87**	
Individual Employment Supports Total:						**117323.09**
Individual Employment Supports	15 min/unit	12	741.80	13.18	**117323.09**	
Personal Assistance/Habilitation (PAB) Total:						**56919845.37**
Personal Assistance/Habilitation Level 1	15 min/unit	1717	2542.60	6.23	**27197963.37**	
Personal Assistance/Habilitation Level 2	15 min/unit	635	4602.40	7.60	**22211182.40**	
Personal Assistance/Habilitation Level 3	15 min/unit	6	6071.40	7.53	**274305.85**	
CD Personal Assistance/Habilitation Level 1	15 min/unit	438	3985.20	2.95	**5149276.92**	
CD Personal Assistance/Habilitation Level 2	15 min/unit	115	4958.70	3.66	**2087116.83**	
Residential Habilitation (ResHab) Total:						**19300470.00**
Residential Habilitation (ResHab)	Day	730	350.00	75.54	**19300470.00**	
Respite Total:						**3072499.70**
Respite Unit	15 min/unit	71	1550.20	3.89	**428149.74**	

Respite Daily	Day	98	76.80	127.40	958863.36	
Respite Consumer Directed Unit	15 min/unit	201	1418.00	2.60	741046.80	
Respite Consumer Directed Daily	Day	179	37.00	142.60	944439.80	
Skilled Nursing Total:						2770774.21
Skilled Nursing RN	15 min/unit	129	3417.20	4.65	2049807.42	
Skilled Nursing LPN	15 min/unit	49	4042.20	3.64	720966.79	
Assistive Technology Total:						25000.00
Assistive Technology	Item	5	5.00	1000.00	25000.00	
Chore Total:						288809.44
Chore Unit	15 min/unit	28	2584.70	3.23	233760.27	
Chore Consumer Directed Unit	15 min/unit	19	1287.70	2.25	55049.18	
Environmental Accessibility Adaptations Total:						80000.00
Environmental Accessibility Adaptations	Service	2	1.00	40000.00	80000.00	
Non-Medical Transportation Total:						93606.37
Transportation Mile	Mile	14	2976.90	1.89	78768.77	
Transportation Trips	Trip	34	218.20	2.00	14837.60	
Personal Emergency Response System (PERS) Total:						2077.41
Personal Emergency Response System (PERS) Service	Service	1	3.00	21.67	65.01	
Personal Emergency Response System (PERS) Monthly	Month	6	7.80	43.00	2012.40	
Specialized Medical Equipment and Supplies Total:						1174.00
Specialized Medical Equipment and Supplies	Item	2	1.00	587.00	1174.00	
Training and Consultation Total:						303702.81
Training and Consultation	Hour	86	44.60	79.18	303702.81	
Vehicular Modifications Total:						50000.00
Vehicular Modifications	Service	2	1.00	25000.00	50000.00	
Waiver Emergency Services Total:						290730.68
Emergency Shelter	Day	11	53.80	475.71	281525.18	
Emergency Outreach	Day	34	3.80	71.25	9205.50	
				GRAND TOTAL:		106542034.45
				Total Estimated Unduplicated Participants:		2799
				Factor D (Divide total by number of participants):		38064.32
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health (ADH) Total:						**23125198.58**
Adult Day Health Level 1	Day	1079	185.20	66.56	**13300738.05**	
Adult Day Health Level 2	Day	484	209.20	83.01	**8404994.93**	
Adult Day Health Level 3	Day	60	201.60	117.35	**1419465.60**	
Discovery & Career Planning (DCP) Total:						**371558.87**
Discovery & Career Planning (DCP)	Hour	31	378.10	31.70	**371558.87**	
Individual Employment Supports Total:						**117323.09**
Individual Employment Supports	15 min/unit	12	741.80	13.18	**117323.09**	
Personal Assistance/Habilitation (PAB) Total:						**57595718.23**
Personal Assistance/Habilitation Level 1	15 min/unit	1736	2542.60	6.23	**27498930.93**	
Personal Assistance/Habilitation Level 2	15 min/unit	643	4602.40	7.60	**22491008.32**	
Personal Assistance/Habilitation Level 3	15 min/unit	6	6071.40	7.53	**274305.85**	
CD Personal Assistance/Habilitation Level 1	15 min/unit	443	3985.20	2.95	**5208058.62**	
CD Personal Assistance/Habilitation Level 2	15 min/unit	117	4958.70	3.66	**2123414.51**	
Residential Habilitation (ResHab) Total:						**19511982.00**
Residential Habilitation (ResHab)	Day	738	350.00	75.54	**19511982.00**	
Respite Total:						**3130771.82**
Respite Unit	15 min/unit	72	1550.20	3.89	**434180.02**	
Respite Daily	Day	100	76.80	127.40	**978432.00**	
Respite Consumer Directed Unit	15 min/unit	207	1418.00	2.60	**763167.60**	
Respite Consumer Directed Daily	Day	181	37.00	142.60	**954992.20**	
Skilled Nursing Total:						**2802554.17**
Skilled Nursing RN	15 min/unit	131	3417.20	4.65	**2081587.38**	
Skilled Nursing LPN	15 min/unit	49	4042.20	3.64	**720966.79**	
Assistive Technology Total:						**25000.00**
Assistive Technology	Item	5	5.00	1000.00	**25000.00**	
Chore Total:						**288809.44**
Chore Unit	15 min/unit	28	2584.70	3.23	**233760.27**	
Chore Consumer Directed Unit	15 min/unit	19	1287.70	2.25	**55049.18**	
Environmental Accessibility Adaptations Total:						**80000.00**

Environmental Accessibility Adaptations	Service	2	1.00	40000.00	80000.00	
Non-Medical Transportation Total:						93606.37
Transportation Mile	Mile	14	2976.90	1.89	78768.77	
Transportation Trips	Trip	34	218.20	2.00	14837.60	
Personal Emergency Response System (PERS) Total:						2077.41
Personal Emergency Response System (PERS) Service	Service	1	3.00	21.67	65.01	
Personal Emergency Response System (PERS) Monthly	Month	6	7.80	43.00	2012.40	
Specialized Medical Equipment and Supplies Total:						1174.00
Specialized Medical Equipment and Supplies	Item	2	1.00	587.00	1174.00	
Training and Consultation Total:						307234.24
Training and Consultation	Hour	87	44.60	79.18	307234.24	
Vehicular Modifications Total:						50000.00
Vehicular Modifications	Service	2	1.00	25000.00	50000.00	
Waiver Emergency Services Total:						290730.68
Emergency Shelter	Day	11	53.80	475.71	281525.18	
Emergency Outreach	Day	34	3.80	71.25	9205.50	
				GRAND TOTAL:		107793738.90
				Total Estimated Unduplicated Participants:		2831
				Factor D (Divide total by number of participants):		38076.21
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health (ADH) Total:						23400973.43
Adult Day Health Level 1	Day	1091	185.20	66.56	13448660.99	
Adult Day Health Level 2	Day	490	209.20	83.01	8509189.08	
Adult Day Health Level 3	Day	61	201.60	117.35	1443123.36	
Discovery & Career Planning (DCP) Total:						371558.87
Discovery & Career Planning (DCP)	Hour	31	378.10	31.70	371558.87	
Individual Employment Supports Total:						117323.09

Individual Employment Supports	15 min/unit	12	741.80	13.18	117323.09	
Personal Assistance/Habilitation (PAB) Total:						58234304.42
Personal Assistance/Habilitation Level 1	15 min/unit	1756	2542.60	6.23	27815738.89	
Personal Assistance/Habilitation Level 2	15 min/unit	650	4602.40	7.60	22735856.00	
Personal Assistance/Habilitation Level 3	15 min/unit	6	6071.40	7.53	274305.85	
CD Personal Assistance/Habilitation Level 1	15 min/unit	448	3985.20	2.95	5266840.32	
CD Personal Assistance/Habilitation Level 2	15 min/unit	118	4958.70	3.66	2141563.36	
Residential Habilitation (ResHab) Total:						19723494.00
Residential Habilitation (ResHab)	Day	746	350.00	75.54	19723494.00	
Respite Total:						3153452.01
Respite Unit	15 min/unit	73	1550.20	3.89	440210.29	
Respite Daily	Day	101	76.80	127.40	988216.32	
Respite Consumer Directed Unit	15 min/unit	206	1418.00	2.60	759480.80	
Respite Consumer Directed Daily	Day	183	37.00	142.60	965544.60	
Skilled Nursing Total:						2833035.00
Skilled Nursing RN	15 min/unit	132	3417.00	4.65	2097354.60	
Skilled Nursing LPN	15 min/unit	50	4042.20	3.64	735680.40	
Assistive Technology Total:						25000.00
Assistive Technology	Item	5	5.00	1000.00	25000.00	
Chore Total:						288809.44
Chore Unit	15 min/unit	28	2584.70	3.23	233760.27	
Chore Consumer Directed Unit	15 min/unit	19	1287.70	2.25	55049.18	
Environmental Accessibility Adaptations Total:						80000.00
Environmental Accessibility Adaptations	Service	2	1.00	40000.00	80000.00	
Non-Medical Transportation Total:						94042.77
Transportation Mile	Mile	14	2976.90	1.89	78768.77	
Transportation Trips	Trip	35	218.20	2.00	15274.00	
Personal Emergency Response System (PERS) Total:						2077.41
Personal Emergency Response System (PERS) Service	Service	1	3.00	21.67	65.01	
Personal Emergency Response System (PERS) Monthly	Month	6	7.80	43.00	2012.40	
Specialized Medical Equipment and Supplies Total:						1174.00
Specialized Medical Equipment and Supplies	Item	2	1.00	587.00	1174.00	
Training and Consultation Total:						310765.66
Training and Consultation	Hour	88	44.60	79.18	310765.66	

Vehicular Modifications Total:						**50000.00**
Vehicular Modifications	Service	2	1.00	25000.00	**50000.00**	
Waiver Emergency Services Total:						**291001.43**
Emergency Shelter	Day	11	53.80	475.71	**281525.18**	
Emergency Outreach	Day	35	3.80	71.25	**9476.25**	
		GRAND TOTAL:				**108977011.54**
		Total Estimated Unduplicated Participants:				**2863**
		Factor D (Divide total by number of participants):				**38063.92**
		Average Length of Stay on the Waiver:				355