Possibilities NOW!

I/DD Waiver Standards Version B-3

Overview of Changes

October 2018

State of Hawaii, Department of Health

Developmental Disabilities Division

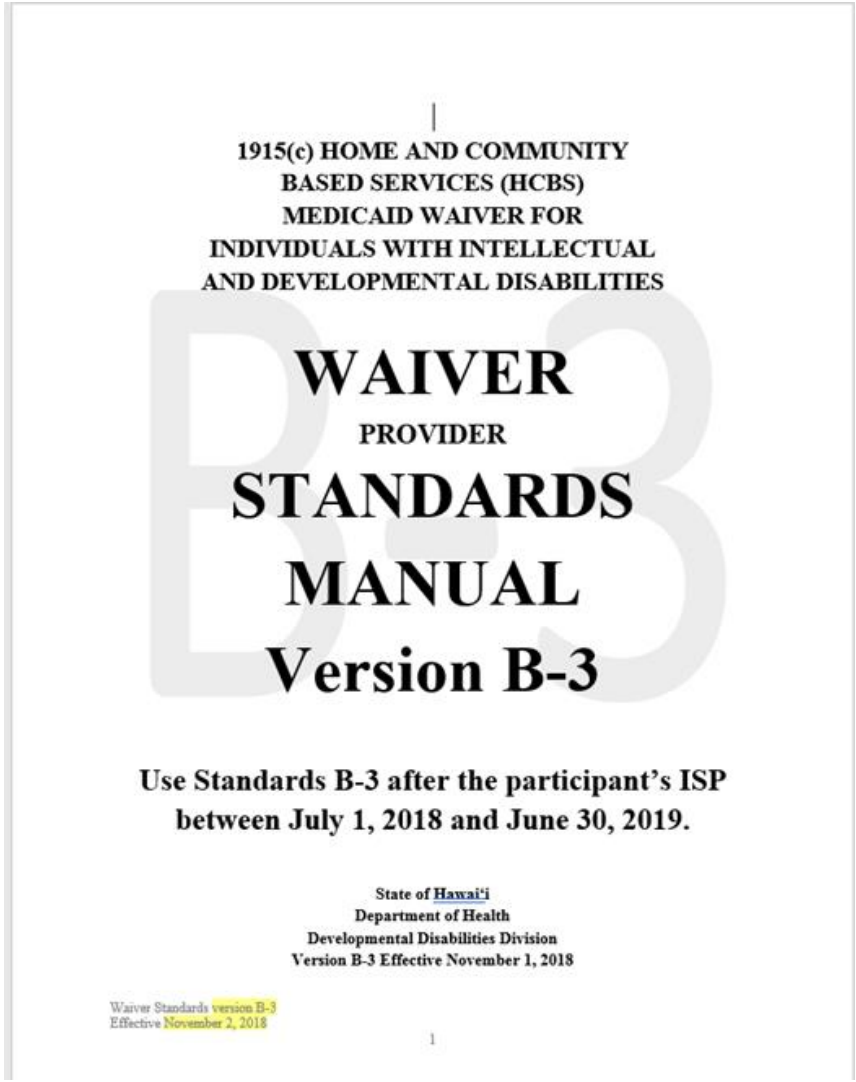
Fostering partnerships and providing quality person-centered and family-focused services and supports that promote self-determination.

Agenda

- Brief overview of changes in Waiver Amendment #2
- Review of all changes in the Waiver Standards version B-3
- Overview of the Exceptions Process

Version B-3

- Issue date was 10/3/18
- Providers must have 30-days notice before effective date
- Effective date is November 2, 2018
- Weren't we switching to Version C?



1915(c) HOME AND COMMUNITY BASED SERVICES (HCBS) MEDICAID WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

WAIVER PROVIDER STANDARDS MANUAL Version B-3

Use Standards B-3 after the participant's ISP between July 1, 2018 and June 30, 2019.

State of Hawai'i
Department of Health
Developmental Disabilities Division
Version B-3 Effective November 1, 2018

Waiver Standards version B-3
Effective November 2, 2018

1

DDD Systems Improvements:

DDD Making Changes to:

- Expand and improve the types of services available.
- Adjust service reimbursement rates.
- Improve the ability to collect and use information on participants to make data-informed decisions.
- Advance the supports planning process.
- Understand participants' support needs by using the Supports Intensity Scale (SIS).
- Increase flexibility and choice with supports budgets.
- Invest in staff, providers, and families.
- Embrace innovation.

Changes in Version B-3

- Primary changes relate to the approved Amendment #2
  - Adding Individual Supports Budgets
  - Adding a new service – Private Duty Nursing
- Clarifications to some services
- Clarifications for providers
  - Service Supervision
  - Staff Qualifications

Section 1: General Requirements and Information

Summary of Changes to B-3 Table

- At the recommendation of Waiver Policy Advisory Committee and other stakeholders, added a summary table for quick reference.

Introduction

- Subsection B: Possibilities Now! – Person-Centered/Family/Centered Practices
  - added language to include self-determination and Individual Supports Budgets

- Subsection C: Community Integration and the HCBS Final Rule
  - clarified the language that new provider applicants must be in full compliance and are not subject to the transition period.

1.3.E Verification of Medicaid Eligibility

1. The Medicaid program will only reimburse Providers for services rendered to participants with current Medicaid eligibility. If a Medicaid I/DD Waiver Provider is unable to verify a participant's eligibility at the time of service, the Provider renders the service at his/her own risk. The prior authorization does not guarantee payment of a claim or verify participant eligibility at the time a service is rendered.

1.5.B Individual Supports Budgets

- Added a new sub-section under Section 1.5 to describe
  - Budget Ranges
  - SIS Levels
  - Residential Living Arrangements
  - Phase In Schedule

Individual Support Budgets and Service Utilization Guidelines

Cohort 1

- 7/1/18 – Phase in to Individual Support Budgets with ISP
- Budgets based on SIS level
- Services planned within budgets

Cohort 2

- 7/1/18 – Services planned within revised service utilization guidelines with ISP
- 7/1/**19** – Phase in to Individual Support Budgets with ISP

Cohort 3

- 7/1/18 – Services planned within revised service utilization guidelines with ISP
- 7/1/**20** – Phase in to Individual Support Budgets with ISP

Section 2:
Waiver Agency Provider General Requirements and Standards

2.1.B General Requirements for Participation as a Medicaid I/DD Waiver Provider

- Added language again in this section for new provider applicants regarding the Final Rule for community integration
- Added information about the second phase of provider applications that includes Med-QUEST requirements.

2.1.G Transition, Coordination and Continuity of Care

1. A Provider initiates action to terminate services for any reason, such as no longer being a willing service provider for a participant or group of participants or an area of the state or ends all waiver services by closing of an agency.

a. The Providers must give written notice to the CM and DOH-DDD Community Resources Branch of any termination of all waiver services at least 30 calendar days prior to the change.

2.1.I Emergency Preparedness

A. Emergency Preparedness

Waiver Providers must have a current Emergency Preparedness plan that addresses the agency's protocols for responding to natural or man-made disasters, technological or infrastructure failures, disease outbreaks or other types of emergencies. Providers must report to DOH-DDD when their emergency preparedness action plan has been implemented and outline steps taken to ensure the safety of the participants and staff. Providers must respond to requests from DOH-DDD within timeframes required when there is a likelihood that emergency preparedness plans will be activated. Providers must also provide updates within DOH-DDD timeframes on the status of participants who may need additional supports as a result of the event.

Section 2.2 General Staff Qualification Requirements

- Added that service supervisors must also receive annual training on the four mandatory topics. This was already in the Table 2.2-1 but was not in the written section.

Table 2.2-1 General Staff Qualifications

- Table was reformatted for accessibility to be read by vision assistive technology
- Corrected language underneath the table for ResHab providers with Independent Contractor Agreements

NOTE: This table does not include ResHab Independent Contractors. ResHab Independent Contractors must provide a copy of the Independent Contractor's current license or certificate to the ResHab provider for its file. The Independent Contractor must be in good standing with the respective licensure or certification agency. As part of its quality monitoring and oversight, the Provider must have a mechanism in place to be notified by the Independent Contractor of any change to the status of their license or certificate.

2.3.A Supervision Responsibilities

1. performing face-to-face observations/reviews of services being delivered to participants at the frequency specified in the ISP or if not specified, at least monthly. Reviews may be in-person or by a technology-based alternative format, such as HIPAA-secure video conferencing, indicated in the ISP. Any alternative format must be HIPAA compliant and must be submitted to DOH-DDD Community Resources Branch for prior approval before using for service supervision.
    a. The standard is the service supervisor observes at least one waiver service being delivered each month (12 visits per year).
    b. If the circle determines at the ISP that there are exceptional circumstances, the ISP can specify a frequency for face-to-face service supervision visits to occur every other month (six visits per year) or once per quarter (four visits per year). Exceptional circumstances are limited to rural locations where travel distance and/or time require the service supervisor to travel to another island or have a typical drive time of 1.5 hours or more each way to reach the participant and staff.
    c. Exceptional circumstances are not permitted for:
        i. ADH and CLS-G by the same provider – alternating months for the "group" of services is required. This also applies if the participant is approved for 1:1 services in the ADH and/or CLS-Ind rather than the typical authorization of ADH and CLS-G.
        ii. Residential Habilitation – monthly or more frequent visits are required, including supervision in the Agency Model and monitoring/oversight in the Independent Contractor Model.
        iii. Extended drive times due to traffic-related delays, construction, or accidents.

2.3.A Supervision Responsibilities

1. For participants receiving both ADH and CLS-G services from the same provider, these services are a "group" such that supervision may be alternated monthly between which service is observed directly, i.e., Service Supervisors are not required to complete a monthly observation for both services. This also includes ADH and CLS-Ind for participants authorized for 1:1 services rather than small group activities. For example, the service supervisor schedules the visit to observe ADH on the even-number months (February, April, etc.) and the visit to observe CLS-G on the odd-number months (January, March, etc.) during the plan year.
2. For participants receiving both PAB and CLS-Ind services from the same provider, these services are a "group" such that supervision may be alternated monthly between which service is observed directly, i.e., Service Supervisors are not required to complete a monthly observation for both services.
    a. For example, the service supervisor may schedule the visit to observe CLS-I on the even-number months (February, April, etc.) and the visit to observe PAB on the odd-number months (January, March, etc.) during the plan year.
    b. If the ISP specifies an exceptional circumstance, the service supervisor schedules the visit to alternate between the two services in the group. For example, if the ISP specifies quarterly visits, the service supervisor may schedule a visit to observe PAB on the 1st and 3rd visits of the plan year and a visit to observe CLS-I on the 2nd and 4th visits of the plan year.

2.3.B Documentation

6. The service, date, duration and location of each supervision face-to-face visit or alternate format observation.

2.4 Minimum Documentation & Reporting Requirements

- Increased the time the Provider has to complete the Individual Plan from seven (7) calendar days to seven (7) business days
- Added to the reports documentation: The Provider quarterly reports must include the date, duration, and location of each service supervision face-to-face observation or alternate format observation completed during the reporting period.
- Added requirements for responding to state and federal requests

2.5 Personnel Records

- Add an attestation if the DSW or applicant does not have a high school diploma or GED

3. high school diploma or General Equivalency Diploma (GED) or for employees with neither a high school diploma nor a GED, written attestation in the employee's personnel file from the Provider that the employee meets the requirements for the position, including but not limited to the ability to understand and follow written and verbal instructions, complete written documentation, and perform the duties required for the position.

DDD is developing an attestation form for all providers to use.

2.6 Provider Quality Assurance Process

- Added information about the law related to Behavior Analysis that gives the I/DD Waiver Providers additional time to build workforce capacity.
- Added an expectation that providers will participate in the National Core Indicator staff Stability surveys.

2.7 Billing and Claims Processing

- Added information about the HIPAA requirements for use of National Provider Identifier numbers.

2.9 Monitoring Provider Agencies

- Added information about findings from fiscal audits

c. Findings

1) Results from the fiscal monitoring visit are issued to the Provider agency within 30 calendar days after the final date of the review.
2) Findings, including the overpayment amount and quality improvement action issues required by Provider agencies through corrective action plans, are reported on the DOH-DDD Fiscal findings report. The findings report is used as a data source for waiver performance measures. DHS-MQD tracks and reports these waiver performance measures to CMS.

Section 3: Service-Specific Performance Standards

Exception Process

- Version B-3 includes language in each of the base services in the "Authorization" section of the service grid.
  - Adult Day Health
  - Chore
  - Community Learning Service – Individual and Group
  - Personal Assistance/Habilitation – with and without levels
  - Respite

Example:

If the participant's request exceeds the Individual Supports Budget amount or service guidelines, the participant has the option to request a review through the DOH-DDD exceptions review process.

3.1 Additional Residential Supports

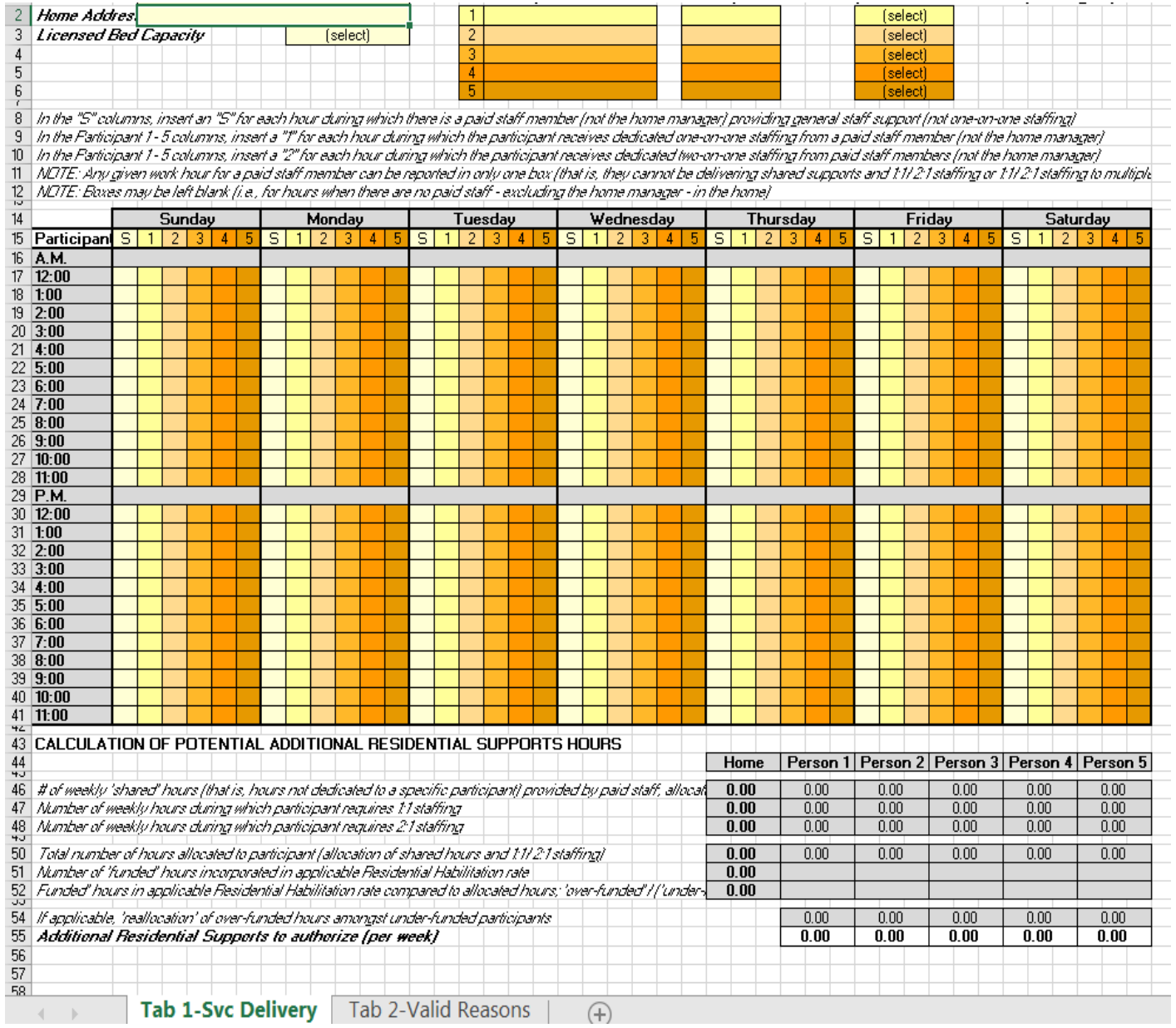
AUTHORIZATION	This service must be prior authorized by DOH-DDD. The Case Manager, with approval by the CMU supervisor and CMB section supervisor, may authorize up to eight (8) hours per day (maximum of 56 hours per week) for a period of less than 60 days. Requests that exceed the hours and/or short-term duration must be submitted through the DOH-DDD exceptions review process. The service must be specified in the Individualized Service Plan (ISP). Additional Residential Supports is a distinct and separate service that can be billed in 15-minute increments during the ResHab day.

3.1 Additional Residential Supports

DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)	A request for Additional Residential Supports must be completed by the provider and submitted to the case manager. 1) DOH-DDD has developed a tool for the provider to document the request. The tool will enable the provider to a) calculate the hours of service delivered across all residents of the home and b) document the valid reason(s) for requesting this service based on the participant's needs; 2) Document the plan for phasing-out the Additional Residential Supports within 60 days. 3) If the service is expected to be needed beyond the 60-day limit, the provider must submit the documentation to the Case Manager to request an extension no later than 21 days before the end of the current approval. The Case Manager will submit the extension request through the DOH-DDD exceptions review process. The Provider will submit additional documentation upon request from DOH-DDD.

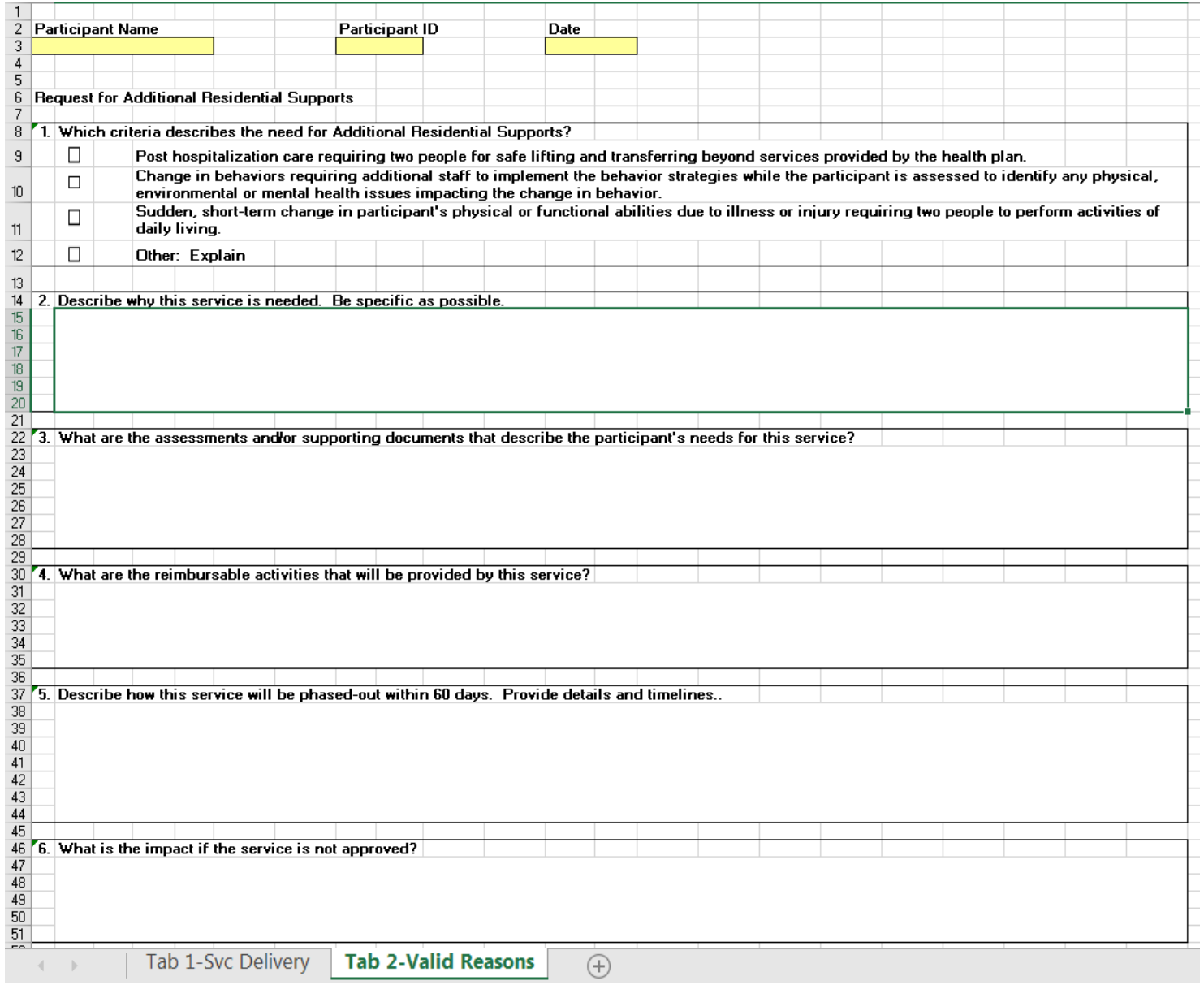
3.1 Additional Residential Supports (continued)

- The Provider will complete the worksheet to calculate the number of hours of ResHab 1:1 services being provided in the home by others (not by the primary caregiver) to all the residents living there
- The hours are computed and an amount will display at the bottom with how many hours of Additional Residential Supports could be authorized.



3.1 Additional Residential Supports (continued)

- The Provider will complete the worksheet to explain the need for the Additional Residential Supports.



Participant Name | Participant ID | Date

Request for Additional Residential Supports

1. Which criteria describes the need for Additional Residential Supports?

- ☐ Post hospitalization care requiring two people for safe lifting and transferring beyond services provided by the health plan.
- ☐ Change in behaviors requiring additional staff to implement the behavior strategies while the participant is assessed to identify any physical, environmental or mental health issues impacting the change in behavior.
- ☐ Sudden, short-term change in participant's physical or functional abilities due to illness or injury requiring two people to perform activities of daily living.
- ☐ Other: Explain

2. Describe why this service is needed. Be specific as possible.

3. What are the assessments and/or supporting documents that describe the participant's needs for this service?

4. What are the reimbursable activities that will be provided by this service?

5. Describe how this service will be phased-out within 60 days. Provide details and timelines..

6. What is the impact if the service is not approved?

Tab 1-Svc Delivery | Tab 2-Valid Reasons

3.2 Adult Day Health

- Added one activity to reimbursable activities list
- Revised the “Interface with Training & Consultation”
- *Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Licensed Professional within scope of practice per Act 205, Session Laws of Hawai‘i 2018*:

  **NOTE the above change will be found throughout the document
- Added language about assisting the participant and family to manage within the authorized hours

3.3 Assistive Technology

- Added programming of devices to the reimbursable activities list
- Added that purchase of tablets must include a protective case and extended warranty
- Changed the assessment requirement to include evaluations from school or other sources that are within one year

3.4 Chore

- Added the exceptions language because it is a base service for people living with family or in their own home

3.5.1 Community Learning Services - Group

- Added the exceptions review language because CLS-G is a base service
- Added the same language regard T&C by behavior analysts, etc.

3.5.2 Community Learning Services - Individual

- Added language regarding exceptions and T&C for behavior analysis
- Added language for use of this service by children.
- Extended completion date for training CLS-Ind workers in community integration (same requirement for CLS-G workers)
- Added requirements for a job coach when CLS-Ind is used long-term to support someone who is working
- Added requirements for a provider to document activities when CLS-Ind is used long-term to support someone who is volunteering
- Clarified that CLS-Ind cannot be used as a requirement for a participant to get or keep a job or to increase the company's productivity.

3.5.2 Community Learning Services - Individual

- Added language to clarify the intent of using CLS-Ind for work or volunteer to separate from job coaching. This change is in the waiver.

CLS-Ind can be used by an individual for ongoing supports to volunteer at non-profit organizations, or work in competitive integrated employment. The primary responsibilities of CLS-Ind staff implementing the service in volunteer or work settings focus on training and assistance in activities of daily living, such as eating, toileting, mobility and transfers which would not be typically provided by co-workers or supervisors at the volunteer or work site.

3.7 Environmental Accessibility Adaptations

- Added language in the waiver and Standards to clarify the definition of additional square footage.

3.8 Individual Employment Supports

- Added language to clarify how to use IES when participants are interested in self-employment
- Added documentation requirement to have a job coach fade plan

3.10.1 Personal Assistance/Habilitation with Levels

- This is the “current” PAB
- Added language to clarify the intent of the service

PAB includes personal assistance, which means the Direct Support Worker (DSW) may perform the care for the participant. However, PAB also includes habilitation, which means the IP must also include strategies for the DSW to implement that teach the participant to acquire, retain or improve a skill for part of the service. Personal care assistance may be a component part of PAB services but may not comprise the entirety of the service.

- Acquire means to learn a new skill that the participant cannot do.
- Retain means to keep a skill that the participant already can do.
- Improve means to get better at a skill the participant can do.

3.10.2 Personal Assistance/Habilitation without Levels

- Don’t be worried about all the “yellow”. We took the B-2 definition that was only for Consumer-Direction and modified to include participants as they transition from the “current” PAB to the PAB without levels. The changes will look very much like the requirements for CLS-Ind.
- Other changes are same as PAB with levels
  - Added language to clarify the intent
  - Exceptions language
  - T&C for behavior supports

  - Note there is an error. PAB workers are not required to complete community integration training (pg. 182)

3.12 Residential Habilitation

- Added language for providers to include substitute caregivers or others in the home who may provide ResHab
- Clarified that ResHab includes transportation to activities in the service description
- Clarified what it means to “not comprise the entirety”

Personal care/assistance may be a component part of ResHab services but may not comprise the entirety of the service. This means ResHab services must primarily implement the IP outcomes that support the participant to learn, improve or maintain skills through teaching and training strategies.

3.12 Residential Habilitation

- Added clarifying language about the 344-day payment rates.

The ResHab payment rates were designed based on a 344-day billing year (by dividing the annual cost of services by 344 days) to accommodate occasional participant absences. The annual limit for ResHab services is therefore 344 units (days) within the ISP plan year. Once a provider has billed 344 units during the ISP plan year, the provider is considered to be paid in full for the 365-day ISP plan year under the ResHab authorization. If a participant changes to a different ResHab Waiver Provider Agency during the ISP plan year, the 344-day limit will reset so the new provider can bill for the remaining days in the authorization period. This only applies when a participant changes providers, not if the participant moves to a different ResHab home within the same Waiver Provider Agency.

3.12 Residential Habilitation

- Added documentation requirements for providers when the participant is requesting an exceptions review process because base services will exceed the Individual Supports Budget.
- The documentation is only required when there is a request submitted to the DOH-DDD exceptions review process. The documentation must be submitted to the case manager within 14 calendar days of the exceptions request. The documentation will cover a one-week period from Sunday through Saturday. For the agency model, a timesheet for a one-week period is required. For the shared living model, the provider can complete an observation of service delivery to attest the amount of time the IP activities require to implement during a one-week period or the caregiver can submit a signed tracking log that lists the activities completed during the one-week period.

3.12 Residential Habilitation

- Added language about provider responsibility if the participant's full access to the community is modified or limited in the ISP.

Modifications to Participant Access:

The Provider must ensure the ResHab caregiver is working toward compliance with the CMS Final Rule for Community Integration (79 FR 2947) and the caregiver does not restrict, limit, or modify the participant's access to the community. The Provider is responsible for documentation requirements and monitoring/oversight of the modification plan that is approved in the ISP. Refer to "REQUIREMENTS FOR HCBS FINAL RULE (79 FR 2947) ON COMMUNITY INTEGRATION" in the Operational Guidelines below this table for more information on the requirements.

3.13 Respite

- Added RN and LPN as qualified providers.
- To authorize Respite by a nurse, the participant also must be receiving another nursing service like Skilled Nursing or Private Duty Nursing
- CRB surveyed providers to develop the list of providers that are offering Respite by a nurse
- This will replace using Skilled Nursing for Respite

3.14.1 Skilled Nursing

- Skilled Nursing will be phasing out during FY2019.
- DDD and MQD are preparing letters to go out to participants and families
- Transitions will occur on a case-by-case basis. DDD and MQD will work with the case manager, participant and family, and provider(s)

3.14.2 Private Duty Nursing

- This is a new service that will replace Skilled Nursing for some participants.
- Available to adults 21 and older who are assessed to have nursing needs and also have habilitation (training) needs
- Children will receive medically-necessary nursing services from the health plans (transitions will be completed on a case-by-case basis)

3.15 Specialized Medical Equipment & Supplies

- Added language that assessment from another program dated within one year can be used for justification

3.16 Training & Consultation

- Clarified T&C for behavior supports with new law Act 205, Session Laws of Hawaii 2018
- Added a table that outline who can do what when the service is delivered by a Licensed Behavior Analyst or designee
- Added language about supervision of RBT and DSW

3.16 Training & Consultation (continued)

- Added language that the supervising professional has to estimate the number of hours a designee will use in order to assist the CM with authorization. NOTE: Designee has different rate/code so you can't authorize everything under the professional

If T&C – Behavior Supports will be delivered by both the licensed professional and the qualified designee, the Provider must advise the Case Manager what the projected number of hours the licensed professional will provide and the number of hours the designee(s) will provide. The Case Manager must enter the authorization using different code/modifiers for T&C. Although hours can be adjusted, the Provider is strongly encouraged to project professional and designee staffing hours as closely as possible to avoid multiple requests for adjustments to the authorizations during the plan year.

3.17 Vehicular Modifications

- Added language for repairs and purchase of extended warranty for the conversion

Exceptions Review

EXCEPTIONS REVIEW
General Overview

- Component of DDD's Utilization Management to evaluate:
  - Appropriateness of care based on assessed needs
  - Fair and equitable use of resources
- Process for reviewing requests for services:
  - Above the individual supports budget
  - Above the service guidelines
  - Above the limits allowed in the Standards

EXCEPTIONS REVIEW
General Overview

- Letter to I/DD Waiver Participants, Families, and Guardians
  - ➢ Informed of changes beginning in July 2018
  - ➢ Described Cohorts
  - ➢ Explained options if the amount and frequency of waiver services were not sufficient to meet the participant's assessed needs
    - Request an Exceptions Review
      - Request for services to stay the same or request additional services (e.g. at the amounts currently authorized)
      - Submit documentation demonstrating why services are needed
      - Decision should be made within 2-4 weeks
    - Request an Appeal Without an Exceptions Review
      - Process to say you don't agree with the state's actions/decisions
      - Informal and Formal processes are available if you disagree

EXCEPTIONS REVIEW COMMITTEE

- Requests for an exceptions review are submitted to the Committee
- Committee comprised of DDD staff: RNs and supervisors from Case Management Branch, Community Resource Branch, Outcomes and Compliance Branch, and DDD Admin
- Reviews service requests based on established criteria
- Conducts case-by-case assessment based on information in the exceptions tool and supporting documentation
- Consults with DDD's Clinical Interdisciplinary Team, if needed
- Determines if request is approved, denied, or modified and makes recommendations based on the participant's assessed needs
- Provides written decision to the case manager

EXCEPTIONS REVIEW PROCESS

- Case manager completes the Exceptions Tool with input of the participant and circle of support and gathers the necessary supporting documentation to explain why services are needed
- Documents are submitted to the Committee for review and decision-making
- The Committee will determine the following based on the information:
  - ✓was the criteria for an exceptions met
  - ✓were other alternatives to meet the participant's needs discussed and explored, including natural supports
  - ✓is there a plan to transition to the supports budget or service utilization guidelines
  - ✓Do the reimbursable activities for the services requested align with the Standards

EXCEPTIONS REVIEW PROCESS

- If the Committee approves the request, the case manager will authorize the services in the ISP for the timeframe approved
- If the Committee denies the request in whole or in part, the case manager will issue a Notice of Action that includes the appeal rights
  - ➢Informal Review with DDD
  - ➢Administrative Hearing with DOH
  - ➢Fair Hearing with DHS

  *During an appeal, services will continue at the current level

Discussion & Questions

Thank You!