DDD 1915(c) Appendix K Operational Guidelines

APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE
VERSION 3

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1915(c) HOME AND COMMUNITY BASED SERVICES WAIVER
APPENDIX K OPERATIONAL GUIDE

What is Appendix K?

In times of emergency such as the COVID-19 pandemic, states which operate 1915(c) Home and Community-Based Services (HCBS) Waiver can apply for approval of "Appendix K: Emergency Preparedness and Response" in order to activate the necessary flexibilities available under the Medicaid 1915(c) authority. Hawaii's Appendix K application for the COVID-19 emergency was approved by the Centers for Medicare and Medicaid Services on March 27, 2020.

These flexibilities are available only for the duration of a federally declared disaster. All services and programmatic changes taken through an approved Appendix K must be based on situations that arise from the emergency and are temporary in nature. Service changes for participants must be directly related to the COVID-19 emergency and the flexibilities under Appendix K are only authorized for the duration of the emergency. We will issue further guidance on transitioning back to pre-emergency services and conditions.

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

Participants and their families should work with their case manager (CM) to determine what supports they might need during this period. One of the many challenges associated with the COVID-19 emergency is that direct care may not be able to be provided as it normally would have. CMs will work closely with providers, participants, and families to ensure coordination and communications.

The purpose of these operational guidelines is to provide guidance on how to implement changes that will be in effect for the duration of the declared COVID-19 emergency. These guidelines will be updated as necessary and will be posted on-line at https://health.hawaii.gov/ddd/ representing the content and dates of changes to the Appendix K Operational Guidelines will be notated on-line.

Note:

- Consumer Directed Services operational guidelines will be issued separately. The link to those guidelines will be provided as it becomes available.
- INSPIRE Service Authorization instructions for CMs will be issued separately. The link to those guidelines will be provided as it becomes available.

Timeframe

The State received approval of Appendix K from the Centers for Medicare and Medicaid Services (CMS) with a retroactive start date of March 1, 2020. The Appendix K changes are explained in this operational guide effective starting March 1, 2020. The Appendix K changes will continue to be in effect until an end date is provided by DDD through a transmittal memo to providers. This end date will reflect the end of the federally-declared emergency for COVID-19.

Once the end date of Appendix K is determined, all changes made to implement Appendix K will end. As all changes in this operational guide are specific to COVID-19 impacts, and Appendix K will end when there are no longer widespread impacts caused by COVID-19, there will no longer be a need for participants to maintain service changes allowable through Appendix K. All changes made to Individualized Service Plans (ISP) to will revert services back to levels prior to being impacted by COVID-19 will not be subject to fair hearing and appeal requirements.

Guide for Determining If Appendix K Applies

All service-related changes contained in this operational guide may only be implemented for participants impacted by COVID-19. Changes beyond those directly related to COVID-19 will not be authorized.

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

1. ***What change(s) occurred for the participant as a result of COVID-19? The participant's needs must be related to one or more of the questions listed in a-l:***

Changes Related to Services

a. Was the participant receiving day services, such as Adult Day Health (ADH), in a setting that closed due to the orders to "shelter in place" and/or CDC advisory for social distancing?
b. Was the participant receiving community-based services, such as Community Learning Services-Group (CLS-G) or Individual (CLS-Ind) or Discovery & Career Planning (DCP), that could not be provided due to the orders to "shelter in place" and/or CDC advisory for social distancing?
c. Was the participant employed and using waiver services, such as Individual Employment Services (IES) or CLS-Ind but is currently not able to work as a result of COVID-19 "shelter in place" requirements and/or CDC advisory for social distancing.
d. Is the provider unable to provide staffing at pre-COVID-19 required levels due to overall shortages of staffing and inability to secure additional staff as a result of the COVID-19 situation?
e. Is the participant's family choosing to not allow direct support workers (DSWs) into their home as part of social distancing?
f. Is the participant's direct support worker unable to provide services due to caring for a family member due to closure of schools or day care programs as a result of COVID-19?
g. Is the participant's direct support worker unable to provide services due to caring for a family member diagnosed with COVID-19?

Changes Related to Health

h. Is the participant isolating at home or quarantined due to potential exposure to someone diagnosed (presumptive or confirmed) with COVID-19?
i. Was the participant diagnosed with COVID-19 that requires relatives to render services when direct support worker are unwilling or unable to provide services while the participant is contagious?
j. Was the participant's caregiver or a person with whom they live diagnosed (presumptive or confirmed) with COVID-19?
k. Is the participant's direct support worker isolating at home or quarantined due to exposure to someone diagnosed (presumptive or confirmed) with COVID-19?
l. Was the participant's direct support worker diagnosed (presumptive or confirmed) with COVID-19?

2. ***Is the change requested covered in this Appendix K operational guide? If not, please contact the participant's case manager for guidance. During this emergency, health and safety activities for individuals and families are paramount.***

Retroactive Authorizations

Services can be retroactively authorized from March 1, 2020 only if they met criteria with the guidance above. Providers should contact the case manager to discuss the need for retroactive authorizations. Case Management Branch Unit Supervisors are available for technical assistance if there are questions about requests.

Case managers will work with providers, participants and families to determine if Appendix K applies to service requests and changes. Due to the need for rapid response in order to ensure participants' health and welfare and to avoid delays while waiting for approval and authorization of ISP changes, documentation of verbal approval or email approval of changes and additions to action plans may suffice as authorization. Case managers may enter the service authorization through INSPIRE retroactively. Providers should wait until after the service authorization is posted on the Department of Human Services' Medicaid On-Line (DMO) to submit their claims but may provide the service based on the verbal or email approval from the case manager. The emergency service authorization period is March 1, 2020-May 31, 2020 (three months).

From Appendix K:

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

a. In emergent situations where the participant's immediate health and safety needs must be addressed, retrospective authorization may be completed.
b. Documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization for provides to deliver services while awaiting data input into the case management system and MMIS.

NOTE: Three waiver services are excluded from this Appendix K Flexibility: Assistive Technology, Environmental Accessibility Adaptations, and Vehicular Modifications. Those services continue to require prior authorization as described in Waiver Standards (B-3) and may not be authorized retrospectively.

General Summary: Service Authorizations:

- The emergency service authorization period is March 1, 2020-May 31, 2020
- Authorizations may be retroactively dated to the start of the emergency authorization period as described above.
- Authorizations related to COVID-19 will be for the duration of the emergency authorization period (three months) unless the individual's plan year begins on April 1, 2020 or May 1, 2020.
- Certain services require clinical approval before the authorization can be created (see Services section for details).
- Case managers may give a verbal or email authorization to a provider at which point the provider may begin the service.
    - The case manager must document the verbal or email authorization in a contact note and create the authorization in INSPIRE as soon as possible using the Emergency Service Authorization Procedures manual.
- Providers are advised to check the Department of Human Services Medicaid On-Line (DMO) for prior authorization confirmation before submitting claims
    - It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created

SERVICES

Flexibility in Authorizing Services	
Appendix K Flexibilities: ….when needed to accommodate changes in service availability for a variety of circumstances that may arise from COVID-19 (e.g., instances when participants are forced to substitute group services with one-to-one services such as when a participant's ADH program closes due to COVID-19 and they convert to using PAB, or when paid supports are needed to substitute for natural supports that become unavailable).	
Operational Guidance	
Case Management	1. CM must check with participant, family/guardian to determine support needs, including amount and frequency of service while sheltering in place. Participant and/or family/guardian have an option to receive supports from an agency or through consumer-directed (CD), if applicable. 2. When the participant and/or family/guardian choose services from an agency, CM to check with the provider for availability of workers. 3. When the participant and/or family/guardian choose CD and the participant is not currently enrolled in the CD program, CM to follow Expedited Procedures to Access Consumer-Directed Options During COVID-19. CD may be considered if the provider is unable to provide the staff or the family chooses not to have the DSW in the home due to social distancing. 4. CM must update the action plan to reflect the change in service and authorized hours. The ISP must document the following: "The change in services from _____ to _____ effective _____ is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends. The change in service is based on the participant's assessed need during the emergency." Example: The change in service from ADH to PAB at 6 hours/day, Monday to Friday effective March 16, 2020 is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends. The change in service is based on the participant's assessed needs during the emergency." 5. Verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary. 6. CM will offer them a choice to use electronic signature or to receive a mailed consent form to sign and return. **Paid supports when natural supports are not available due to COVID-19** 1. CMs may authorize additional waiver services when natural supports are unavailable due to COVID-19 (e.g., family member diagnosed with COVID-19, family member is designated as an essential worker, family member is quarantined and cannot provide supports). 2. CM must assess the participant's needs and frequency of service. 3. When necessary services exceed the individual budget, the CM, based on discussion with the CM Supervisors, may approve the increase when there is evidence that paid supports are needed based on the COVID-19 guidance on page 5. (Document in Contact Notes in INSPIRE). 4. CM must update the action plan to reflect the additional or increase in service hours with an effective date and must include the statement that services is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends.

	Example: The increase in PAB services from 4 hours/day to 6 hours/day, Monday to Friday effective March 23, 2020 is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends." 5. Verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary 6. CM will offer them a choice to use electronic signature or to receive a mailed consent form to sign and return. NOTE: An exceptions review will not be required, unless request is for enhanced staff ratio (2:1 or 3:1) and enhanced supports (24/7 waiver services). Requests for enhanced staff ratio and supports will require an exceptions review, including review by CIT.
Providers	<u>Service Authorization:</u> a. The provider will contact the CM via phone or email when there is a change in service availability. Example of a change in service availability: the ADH facility is no longer open but the participant still needs some support during the day. b. The provider may begin delivering an approved change in service (i.e., type of service and/or hours for an existing service) after receiving a verbal or an email authorization from the CM. c. After five (5) business days from receiving the verbal or emailed authorization from the CM, the provider should check the Department of Human Services' Medicaid Online (DMO) to verify that the change in service authorization was processed. i. The CM should be contacted as soon as possible if the provider is unable to view the change in DMO after the five (5) days. <u>Billing</u>: a. The provider must verify that changes in service authorizations are in DMO before submitting any claims/billing. b. The provider must pay close attention to the service authorizations during this COVID-19 emergency and ensure claims are submitted for the correct service. <u>Documentation:</u> a. The provider must continue to complete and maintain service delivery documentation, records and reports in accordance with the requirements in Standards (B-3). i. Documentation during the COVID-19 emergency period must also include what change in service(s) occurred and a brief description of the reason for the change (related to the COVID-19 emergency).
References: Standards (B-3), Section 2.5.A	

<table>
<tr><th colspan="2">Service Definition/Limits/Location – Adult Day Health (ADH)</th></tr>
<tr><td colspan="2">Appendix K Flexibilities:
1. ADH may be provided in participants' home, whether in a licensed or certified setting or a private home. When provided in a licensed or certified setting, the services cannot be provided by a member of the household.
2. Minimum staffing ratios as required by the waiver service definition, provider standards and/or specified in the Individualized Service Plan (ISP) may be exceeded due to staffing shortages.</td></tr>
<tr><td colspan="2">Operational Guidance</td></tr>
<tr><td>Case Management</td><td>1. ADH Provided in the Participant's Home
a. CM may authorize ADH in the participant's home. Social distancing shall be practiced at all times.
b. See Appendix A decision tree for ADH/CLS-G to determine appropriate service.

2. N/A</td></tr>
<tr><td>Providers</td><td>1. ADH Provided in the Participant's Home (private, licensed or certified home)
a. ADH-G may be provided to participants who reside in the same home
b. ADH 1:1 may be provided based on the participant's support needs.
i. The CM will work with the participant, family/guardian and provider(s) to determine support needs, including amount and frequency of services while sheltering in place.
c. ADH in a licensed or certified home may not be provided by a member of the household.
d. The provider must ensure that social distancing guidelines are followed at all times.
e. ADH services may be delivered via telehealth, when appropriate.
i. The provider must verify that the participant's needs may be adequately supported via telehealth and ensure their health and safety.
f. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (B-3).
i. Documentation during the COVID-19 emergency period must also include the change in service location and/or delivery method (e.g., telehealth) and a brief description of the reason for the change (related to the COVID-19 emergency).

1. Minimum Staffing Ratios
a. May exceed the required minimum staffing ratio of 1:6 due to staffing shortages, as long as the health and safety of the participants are ensured, and social distancing guidelines are met.
b. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (B-3).
i. Documentation during the COVID-19 emergency period must also include the staffing ratio, reason(s) if the minimum staffing ratio was exceeded and how social distancing guidelines were met.</td></tr>
<tr><td colspan="2">References: Waiver Appendix C1/C3, Standards (B-3) Section 3.2</td></tr>
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Service Definition/Limits – Additional Residential Supports (ARS)	
Appendix K Flexibilities: Appendix K permits the I/DD Waiver to expand the allowable use of the service to provide supports in licensed and certified settings when needed to replace community services that the participant can no longer access. 1. Can be provided for an urgent situation where the caregiver or substitute caregiver are unavailable to provide services during times when the participant would typically have been able to access daytime activities such as ADH. 2. May be extended beyond the short-term duration requirement during a declared public health emergency. 3. Temporarily permit payment for certain waiver services provided to participants who are in a hospital or other short-term facility (excluding ICF/IID). Payments ~~cannot~~ during a short-term institutional stay other than a hospital shall not exceed 30 consecutive days.	
Operational Guidance	
Case Management	**1. ARS for Urgent and/or Unavoidable Situations** a. CM will be notified by the provider when ARS is requested to support the participant in instances where the licensed or certified caregiver and substitute caregiver are unavailable (e.g., caregiver and substitute caregiver are positive for COVID-19, designated as essential workers, hospitalized, or quarantined) to provide services during times when the participant would typically have been able to access daytime activities. b. CM will consult with CIT by phone to assess need for ARS if a clinical review is warranted. c. CM must document in the ISP the following: "ARS at _____ hours/day effective _____ is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends." Example: ARS at 4 hours daily effective March 30, 2020 is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends. d. Verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary. e. The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return. CM may obtain verbal approval from the participant and/or legal guardian. **2. CM may continue to approve ARS beyond the short-term limit, during the emergency. An exceptions review will not be required.** **3. ARS for Hospitalization or Placement in Short-Term Facility (Excluding ICF/IID)** a. CM may approve ARS to allow the ResHab provider to support the participant who is temporarily hospitalized or placed in a short-term institutional setting (not an ICF/IID). The provider will not be required to complete the ARS tool. b. CM must document in the ISP the following: "ARS at _____ hours effective _____ to support the participant's hospitalization is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends." c. There are two additional documentation requirements in the ISP when ARS is delivered to support a participant in an **acute care hospital**. i. The CM must describe what supports would be provided by the ARS worker. The following list are the categories of supports included in the approved Appendix K

	amendment #2. Examples to describe supports are added to assist the CM and circle of supports. 1) communication, such as cuing and assistance with a participant who is non-verbal 2) behavior support, such as implementing a behavior support plan 3) intensive personal care needs, such as cuing and assistance with a participant to maintain functional abilities 4) NOTE: The participant may have other needs; however, ARS can only be provided if one or more of the reasons listed in (1) through (3) is documented in the ISP. ii. The ISP must include a statement about how the service will assist the participant in returning to the community after hospitalization.
Providers	**1. ARS for Urgent and/or Unavoidable Situations** a. The provider will contact the CM when the participant needs ARS due to an urgent and/or unavoidable situation as a result of the COVID-19 state of emergency. i. An urgent situation shall be described as an immediate, unavoidable circumstance. ii. Examples of urgent and/or unavoidable situations: (1) the caregiver and/or substitute caregiver being unavailable due to illness (i.e., caregiver and substitute caregiver are positive for COVID-19, hospitalized, or quarantined); (2) caregiver and/or substitute caregivers are designated as essential workers and are unavailable to provide services during times when the participant would typically have been able to access daytime activities, such as employment or natural supports; (3) escalation in participants' behavior due to restricted or limited access to daytime activities. b. ARS Tool will not be required during the COVID-19 emergency. c. ARS may be authorized as a 1:1 or group service, depending on the number of residents in the home requiring the service **2. ARS may continue to be approved beyond the short-term limit, during the emergency. An exceptions review will not be required.** **3. ARS for Hospitalization or Placement in Short-Term Facility (Excluding ICF/IID)** a. The provider will contact the CM, when the participant is in a hospital or short-term institutional setting (not an ICF/IID) and requires additional supports during the stay, to authorize the service aligned with where the participant resides: i. If the participant has been living in their family or own home, the service will be PAB. ii. If the participant has been living in a licensed or certified ResHab home, the service will be ARS.

	b. The provider must also: i. Document the participant's need for additional support, such as assistance with communication, ~~or~~ behavioral supports, and/or intensive personal care needs. ii. Document that the services are not covered in the setting where the participant is staying and do not duplicate services that are typically rendered in that setting. iii. Document how the service is assisting the participant to transition back to their home if they are in an acute care hospital. c. ARS Tool will not be required during the COVID-19 emergency. NOTE: ARS ~~in these situations~~ cannot exceed 30 consecutive days if supporting a participant in a short-term institutional setting. There is no time limit for supporting a participant during a stay in an acute care hospital admission. <u>Billing Instructions</u>: If ARS is used to support a participant while hospitalized or in a nursing facility, the provider must enter the Place of Service on the claim. For hospital, **enter "21" as the Place of Service**. For nursing facility, **enter "31" as the Place of Service**. This information is important for data tracking and analysis by DDD and MQD for the report to the Centers for Medicare and Medicaid Services (CMS) after the declared public health emergency has ended.
References: Waiver Appendix C1/C3, Standards (B-3) Section 3.1	

Service Definition/Limits – Community Learning Services – Group (CLS-G)	
Appendix K Flexibilities: Minimum staffing ratios as required by the waiver service definition, provider standards and/or specified in the Individualized Service Plan (ISP) may be exceeded due to staffing shortages.	
Operational Guidance	
Case Management	N/A
Providers	a. The provider may exceed the required minimum staffing ratio of 1:3, due to staffing shortage, as long as the health and safety of the participants are ensured, and social distancing guidelines are met. b. The provider must complete and maintain service delivery documentation, records and reports in accordance with the requirements in Waiver Standards (B-3). i. Documentation during the COVID-19 emergency period must include the staffing ratio, reason(s) if the minimum staffing ratio was exceeded and how social distancing guidelines were met. Services must adhere to current city, county and state mandates.
References: Waiver Appendix C1/C3, Standards (B-3) Section 3.5	

Service Definition/Limits – Medical Respite – NEW SERVICE	
Appendix K Flexibilities: Appendix K allows Hawaii to temporarily add services to the waiver to address the emergency situation. Hawaii added a new service, Medical Respite, to address needs related to the impacts of COVID-19.	
Operational Guidance	
Performance Standards	**Service Description** During a declared public health emergency, Medical Respite is a daily service for participants who have needs related to a COVID-19 diagnosis, including those participants who have tested positive or are presumptive positive and require self-isolation, have been exposed to COVID-19 and require quarantine, and/or during recovery from the disease. Medical Respite services must not duplicate services available to a participant under the Medicaid State Plan, QUEST Integration health plan or any third-party payer. Per the Centers for Disease Control (CDC): (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html) *"Quarantine is used to keep someone who might have been exposed to COVID-19 away from others. Someone in self-quarantine stays separated from others, and they limit movement outside of their home or current place."* *"Isolation is used to separate sick people from healthy people. People who are in isolation should stay home. In the home, anyone sick should separate themselves from others by staying in a specific "sick" bedroom or space and using a different bathroom (if possible)."* **Location of Medical Respite** For participants living in their family or own home, Medical Respite may be provided in the participant's home or in any non-institutional setting where the participant is located, such as the home of a friend or relative, hotel or motel, or other setting that meets the participant's health and safety needs. For participants living in a licensed or certified setting, Medical Respite may be provided in any non-institutional setting when the participant needs to temporarily move from their setting for health and safety reasons of the participant and other residents of the home. Medical Respite may not be provided in a licensed or certified home. Other services such as Private Duty Nursing (PDN) may be available to a participant who is in self-isolation or quarantine in a licensed or certified home. **Reimbursable Activities** Medical Respite ensures participant's health, safety and welfare through a 24-hour day and must include the supervision or provision of assistance to meet participant needs in the following areas: 1) Preventing the spread of COVID-19 NOTE: Staff delivering Medical Respite must use appropriate personal protective equipment (PPE) and observe all infection control practices.

2) Periodic symptom monitoring
3) Providing symptom treatment, including seeking appropriate medical attention for worsening symptoms
4) Keeping in close communication with the participant's circle of support including their legal guardian(s), parent(s)/caregiver(s), family and case manager.

Medical Respite may also include the supervision or provision of assistance with:
1) Routine health needs such as nurse delegated tasks
2) Activities of Daily Living (bathing, toileting, etc.)
3) Meal preparation
4) If provided by an RN or LPN, use nursing judgement and perform skilled interventions that may arise during service delivery

Transportation
Transportation is not included in the service.

Staff to Participant Ratio
One provider staff may deliver Medical Respite at a ratio of:
1:1 – one (1) staff to one (1) participant

Provider Qualification Standards
Qualified providers of Medical Respite include:
- Registered Nurse (RN) in accordance with Hawaii state law
- Licensed Practical Nurse (LPN) in accordance with Hawaii state law and working under the supervision of a Registered Nurse
- Certified Nurse Aide (CNA) in accordance with Hawaii state law and working under the supervision of a nurse

Supervision
The RN will provide supervision at the amount and frequency needed to ensure the participant's health and safety.

RNs providing Medical Respite do not require service supervision.

Authorization
Medical Respite will be authorized at the RN staff level and with or without room and board, which shall be determined by the location where the service will be delivered.

Medical Respite delivered in a private residence, such as the participant's family or own home or the home of a friend, relative or worker, is authorized without room and board.

Medical Respite provided in any non-institutional or non-licensed or certified setting where the participant is temporarily re-located to, such as a hotel or motel, or other setting that meets the participant's health and safety needs, is authorized with room and board.

	NOTE: Claims will be reconciled through manual processing using the correct modifier that identifies the level of staff who delivered the majority of service for each day billed. See Provider Billing Instructions for more information. **Documentation** Medical Respite delivered by a provider must follow service delivery documentation requirements for Maintenance of Participant Records as described in Waiver Standards (B-3), Section 2.5.A. In addition, an RN must provide weekly written updates to the CM by email or fax. The RN may be the staff delivering the service or supervising the work of the LPN and/or CNA. The updates must include the participant's health status and transition planning that focuses on assisting the participant to return home (if applicable). A transition plan is not required if Medical Respite is provided in the participant's family or own home.
Case Management	**Authorization:** A. CM may approve Medical Respite on a short-term basis when the participant: 1) has needs related to a COVID-19 diagnosis: a) has tested positive or is presumptive positive and requires self-isolation b) has been exposed and requires quarantine c) is recovering from the COVID-19 disease and requires self-isolation 2) will receive the services in one of the permitted locations for Medical Respite. NOTE: Medical Respite must not duplicate services available to a participant under the Medicaid State Plan, QUEST Integration health plan or any third-party payer. B. The CM will work with the participant, family/guardian/caregiver and provider to determine the location where Medical Respite will be provided. 1) When the provider is authorized for Medical Respite with room and board, the provider will be responsible for facilitating discussions with the participant, family/guardian/caregiver and CM and establishing the location where Medical Respite will be provided. C. CM will enter the authorization for Medical Respite by RN, with or without room and board, which shall be determined by the location where the service will be delivered. Please refer to Performance Standards, Authorization section for details. D. CM must work with the participant and circle of supports to start developing a transition plan when the delivery of Medical Respite begins. 1) The transition plan shall identify the steps needed for the participant to return to their residence as quickly as possible once they are no longer required to isolate or quarantine. A transition plan is not required if Medical Respite is provided in the participant's family or own home.

	2) The requirement to end isolation or quarantine shall be determined by a physician or public health official. E. CM may authorize other waiver services on the same day as Medical Respite when the participant has additional needs. Other waiver services must be distinct and unique from Medical Respite and may be delivered in-person or by telehealth based on the participant's needs. Examples may include: 1) Specialized Medical Equipment & Supplies for personal protective equipment (PPE) and infection control supplies. 2) Training and Consultation services 3) Other waiver services, such as Adult Day Health, Personal Assistance/Habilitation, and Discovery and Career Planning, when a participant has continued habilitative needs and chooses to continue to receive training to maintain skills and work toward habilitation outcomes. NOTE: Other waiver services authorized on the same day as Medical Respite shall not be provided by the staff providing the Medical Respite.

Providers	For any current I/DD Waiver provider interested in becoming a Medical Respite provider, CRB will work with the provider to become qualified to deliver the new service. **Authorization** A. This service can only be authorized if the participant has needs related to a COVID-19 diagnosis, including: 1) has tested positive or is presumptive positive and requires self-isolation 2) has been exposed and requires quarantine 3) is recovering from the COVID-19 disease and requires self-isolation B. When the provider is authorized for Medical Respite with room and board, the provider will be responsible for facilitating discussions with the participant, family/guardian/caregiver and CM to establish the location where Medical Respite will be provided. 1) The provider will submit an email to the CM with the location where Medical Respite will be delivered. DDD will review the location and may request additional information or deny the location if it cannot meet the participant's health and safety needs. C. The provider shall work with the CM, participant and circle of supports to develop a transition plan upon the delivery of Medical Respite. 1) The transition plan shall identify the steps needed for the participant to return to their residence as quickly as possible once they are no longer required to isolate or quarantine. A transition plan is not required if Medical Respite is provided in the participant's family or own home. 2) The requirement to end isolation or quarantine shall be determined by a physician or public health official. **Supervision** The RN will provide supervision at the amount and frequency needed to ensure the participant's health and safety. RNs providing Medical Respite do not require service supervision. **Documentation:** Medical Respite delivered by a provider must follow service delivery documentation requirements for Maintenance of Participant Records as described in Waiver Standards (B-3), Section 2.5.A. In addition, an RN must provide weekly written updates to the CM by email or fax. The RN may be the staff delivering the service or supervising the work of the LPN and/or CNA. The updates must include the participant's health status and transition planning that focuses on assisting the participant to return home (if applicable).

Billing Instructions:

A. This is a new service with a new code, multiple modifiers and rates for the following:

1) Medical Respite, by RN, with room & board, per day
2) Medical Respite, by LPN with room & board, per day
3) Medical Respite, by CNA, with room & board, per day
4) Medical Respite, by RN, without room & board, per day
5) Medical Respite, by LPN without room & board, per day
6) Medical Respite, by CNA, without room & board, per day

NOTE: Medical Respite rates are the same for all islands.

B. The provider must ensure the health and safety of the participant for the entire 24-hour day. The respite staff must deliver a minimum of 12 hours of face-to-face services in one day to be eligible to bill one unit of service.

C. The service will be authorized by the CM at the "by RN" staff qualification level. If the service will be provided by a combination of RNs, LPNs and CNAs, the provider must use the correct modifier with the billing code to identify the staff qualifications for the worker that **provided the majority of services** for each day billed. Conduent will manually process the claims and pay according to the rate corresponding to the staff qualification.

EXAMPLE (for calculating majority of services): The participant is authorized for Medical Respite, by RN, without room & board. The CNA works 14 hours and the RN works 10 hours on one day; the provider shall submit the claim for Medical Respite, by CNA, without room & board.

D. The provider must maintain documentation that tracks which staff qualification level (RN, LPN, CNA) provided the majority of services for each day to be billed.

References: Appendix K Amendment #2

<table>
<tr><th colspan="2">Service Definition/Limits – Personal Assistance/Habilitation (PAB)</th></tr>
<tr><td colspan="2">Appendix K Flexibilities:
Temporarily permit payment for certain waiver services provided to participants who are in a hospital or other short-term facility (excluding ICF/IID). For participants residing in their own home or their family's home, the authorized service is PAB. Payments ~~cannot~~ during a short-term institutional stay other than a hospital shall not exceed 30 consecutive days.</td></tr>
<tr><td colspan="2">Operational Guidance</td></tr>
<tr><td>Case Management</td><td>PAB for Hospitalization or Placement in Short-Term Facility (Excluding ICF/IID)
1. CM may approve PAB to support the participant living in their own or family home who is hospitalized or placed in a short-term facility.
2. CM must document in the ISP the following: "PAB at _____ effective _____to support the participant's hospitalization is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends."
3. There are two additional documentation requirements in the ISP when PAB is delivered to support a participant in an acute care hospital.
a. The CM must describe what supports would be provided by the PAB worker. The following list are the categories of supports included in the approved Appendix K amendment #2. Examples to describe supports are added to assist the CM and circle of supports.
1) communication, such as cuing and assistance with a participant who is non-verbal
2) behavior support, such as implementing a behavior support plan
3) intensive personal care needs, such as cuing and assistance with a participant to maintain functional abilities

NOTE: The participant may have other needs; however, PAB can only be provided if one or more of the reasons listed in (1) through (3) is documented in the ISP.

b. The ISP must include a statement about how the service will assist the participant in returning to the community after hospitalization</td></tr>
<tr><td>Providers</td><td>PAB for Hospitalization or Placement in Short-Term Facility (Excluding ICF/IID)
1. The provider will contact the CM, when the participant is in a hospital or short-term institutional setting (not an ICF/IID) and requires additional supports during the stay, to authorize the service aligned with where the participant resides as follows:
a. If the participant has been living in their family or own home, the service will be PAB.
b. If the participant has been living in a licensed or certified ResHab home, the service will be ARS.
2. The provider must also:
a. Document the participant's need for additional support, such as assistance with communication, ~~or~~ behavioral supports, and/or intensive personal care needs.
b. Document that these services are not covered in the setting where the participant is staying and do not duplicate services typically rendered in that setting.</td></tr>
</table>

	c. Document how the service is assisting the participant to transition back to their home if they are in an acute care hospital. NOTE: PAB cannot exceed 30 consecutive days if supporting a participant in a short-term institutional setting. There is no time limit for supporting a participant during a stay in an acute care hospital admission. Billing Instructions: If PAB is used to support a participant while hospitalized, the provider must **enter "21" in the Place of Service** field on the claim. For nursing facility, **enter "31" as the Place of Service.** This information is important for data tracking and analysis by DDD and MQD for the report to the Centers for Medicare and Medicaid Services (CMS) after the declared public health emergency has ended.
References: Waiver Appendix C1/C3, Standards (B-3) Section 3.10	

Service Definition/Limits – Private Duty Nursing (PDN)	
Appendix K Flexibilities: The 8-hour limit per day and 30-day short-term limit are suspended if increases in amount or duration of PDN are needed to protect participant health and safety. Such requests above these limits require exceptions review and approval by DOH/DDD. During the declared public health emergency, the participant may receive PDN without also being required to receive at least one (1) habilitative service. A participant may receive PDN and another waiver service at the same time when the second staff performs distinct and separate duties and the requirement that the second staff must perform training in activities of daily living is expanded to include supporting the participant's communication, behavioral needs and/or intensive personal assistance needs. PDN may be provided to participants who have medical needs related to COVID-19 diagnosis, presumptive positive, exposure and/or recovering, without requiring a functional needs assessment. The requirement that the participant requires less than 24 hours-per-day on an ongoing long-term basis may be suspended. PDN may be provided to participants residing in licensed or certified homes. The participant can receive hourly PDN services and Residential Habilitation (ResHab) during the same day. PDN may be provided by any qualified RN or LPN who is member of the household (lives at the same address) and is employed by a waiver provider.	
Operational Guidance	
Case Management	The changes in PDN are intended to expand the service definition and Waiver Standards B-3 to support participants whose needs may have changed due to impacts of the COVID-19 pandemic. A participant may need PDN as a new service to meet health and safety needs or if currently receiving PDN, a participant may need additional hours during the emergency period. **Additional PDN hours – participant currently receives PDN** 1) The participant, family/guardian or provider may contact the CM to request additional PDN hours. 2) Unit RN or RN designee must review request and supporting documentation by the provider to confirm that additional PDN hours are necessary to protect participant health and safety. 3) Unit RN or RN designee will complete the functional assessment, which may be done by telehealth and/or record review, within 24 hours of the request. NOTE: A functional assessment is not required if the reason for additional PDN hours is due to medical needs related to COVID-19 diagnosis, presumptive positive, exposure and/or recovery. The Unit RN or RN designee may forward the request directly to the Unit supervisor. 4) Unit supervisor shall review ~~and approve PDN hours~~ and document in the tracking log.

5) Requests for PDN above the 8-hours-per day limit and 30 day short-term limit may be approved for reasons other than those listed in Waiver Standards B-3 but will require an expedited review by the Clinical Interdisciplinary Team.

~~7)~~ If request for PDN is approved, CM must document in the ISP the following: "The increase in PDN hours from _____ to _____ hours effective _____ is temporary and time limited. ~~for duration of declared emergency, and will end when the state of emergency ends."~~

Example: The increase in PDN hours from 6 hours per day to 9 hours per day effective March 20, 2020 is temporary and time limited ~~for duration of declared emergency, and will end when the state of emergency ends."~~

8) Verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary.

9) CM will offer the participant and/or legal guardian a choice to use electronic signature or to receive a mailed consent form to sign and return.

~~NOTE: Requests for additional PDN above the limits will not require an Exceptions Review, but will require approval by the case management supervisor if the need for additional~~.

Request to Add PDN as a New Service – participant was not receiving PDN prior to the COVID-19 pandemic

1) The participant, family/guardian or provider may contact the CM to request PDN services.

2) Unit RN or RN designee must review request and supporting documentation by the provider to confirm that the need for PDN services is due to the impacts of the COVID-19 pandemic and necessary to protect participant health and safety.

3) Unit RN or RN designee will complete the functional assessment, which may be done by telehealth and/or record review, within 24 hours of the request.

NOTE: A functional assessment is not required if the reason for requesting PDN is due to medical needs related to COVID-19 diagnosis, presumptive positive, exposure and/or recovery. The Unit RN or RN designee may forward the request directly to the Unit supervisor.

4) Unit supervisor shall review and document in the tracking log.

5) Requests for PDN above the 8-hours-per day limit and 30 day short-term limit will require an expedited review by the Clinical Interdisciplinary Team.

6) If request for PDN is approved, CM must follow documentation requirements listed in previous section ("Additional PDN hours due to COVID-19").

PDN Requirement for Habilitative Service

The CM can authorize PDN services without the participant receiving at least one (1) habilitative service.

~~Participants will be allowed to receive PDN services and no habilitative service during the public health emergency.~~

PDN With Other Waiver Services at the Same Time

The CM can authorize PDN and another waiver service at the same time when the participant has a need for a second staff to perform distinct and separate duties.

	1) The Appendix K flexibility expands the reasons to authorize a second service DSW to include supporting the participant's communication, behavioral needs and/or intensive personal assistance needs 2) Unit RN or RN designee will assist the CM in determining if the additional waiver service is needed, during the functional assessment. **PDN for Less Than 24 Hours Daily on a Long-Term Basis** The Appendix K flexibility enables the CM to authorize PDN if a participant has needs for up to 24-hour a day or has needs that are expected to be short-term, such as while recovering from the COVID-19 disease. **PDN for participants residing in a licensed or certified home** 1) PDN may be provided to participants while residing in licensed or certified homes during the public health emergency. 2) The participant may receive hourly PDN services and Residential Habilitation (ResHab) during the same day. **PDN by a Qualified RN or LPN Household Member** PDN may be provided by any qualified RN or LPN who is member of the household (lives at the same address) and is employed by a waiver provider. For participants residing in a licensed or certified home, PDN cannot be provided by the primary licensed or certified caregiver who is an RN or LPN.
Providers	Providers must continue to meet the Performance Standards for PDN services, stated in the Waiver Standards (B-3), Section 3.14.2, in addition to the following: **PDN or Additional PDN Hours Due to COVID-19** 1) The provider will conduct a brief screening of the participant's situation before requesting PDN or PDN above the limit. a. Screening questions to help determine if PDN is needed (i.e. participant currently not receiving the service): i. Is the participant 21 years of age or older? ii. Does the participant have medical needs related to COVID-19 diagnosis, presumptive positive, exposure and/or recovery? NOTE: If answer "Yes" to this question, request may be sent to CM and the remaining question does not need to be answered. iii. Is the participant's need for this service the result of at least one of the conditions listed under the "Guidance for Determining Whether Appendix K Applies" (on page 5)? Please provide a brief description in email to the CM.

	b. Screening questions to help determine if an increase in the amount or duration of PDN is needed (i.e. the participant currently receives PDN): i. Does the participant have medical needs related to COVID-19 diagnosis, presumptive positive, exposure and/or recovery? NOTE: If answer "Yes" to this question, request may be sent to CM and the remaining question does not need to be answered ii. Is the participant's need for an increase in this service the result of at least one of the conditions listed under the "Guidance for Determining Whether Appendix K Applies" (on page 5)? Please provide a brief description in email to the CM. 2) After a request is submitted to the CM, the provider shall: a. Work with the CM, CM unit RN and/or CM unit RN designee to inform the functional assessment. NOTE: PDN may be provided to participants who have medical needs related to COVID-19 diagnosis, presumptive positive, exposure and/or recovery, without requiring a functional needs assessment. b. Coordinate the split of projected RN and/or LPN hours needed and submit to the CM via email.
References: Waiver Appendix C1/C3, Standards (B-3) Section 3.14.2	

Service Definition/Limits/Location – Respite	
Appendix K Flexibilities: 1. Suspend the annual limit of 760 hours of Respite when needed to address potential health and safety issues due to the unavailability of services and/or natural supports that the participant has been receiving. 2. Respite services may be provided in any non-institutional setting where the participant is located (e.g., hotel/ motel or in someone else's home with a staff person). Services in these expanded settings will be reimbursed based on the current rate methodology, which does not include room and board expenses.	
Operational Guidance	
Case Management	**1. Respite Services due to COVID-19** a. The CM shall document in the ISP the need for respite to address potential health and safety issues due to the unavailability of services and/or natural supports that participant had been receiving. b. Unit supervisor shall review request, verify need for services, approve respite hours and document in the tracking log. c. CM must document in the ISP the following when additional hours of respite is authorized "An increase of respite from l _____ hours to _____ hours effective _____ is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends." d. Example: An increase of respite from 16 hours/week to 30 hours/week effective March 23, 2020 is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends. e. CM must document in the ISP the following when there is a new authorization for respite: "Respite at 30 hours/week effective March 23, 2020 is temporary, time limited for duration of declared emergency, and will end when the state of emergency ends. f. Verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary. g. The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return.CM may obtain verbal approval from the participant and/or legal guardian. NOTE: Case managers will not be required to complete the Respite Tool when the request is due to COVID-19. Requests for respite above the annual limit of 760 hours will not require an Exceptions Review but will require approval by the case management supervisor when needed to address potential health and safety issues due to the unavailability of services and/or natural supports that the participant has been receiving. **2. Location of Respite Services** CM may approve hourly respite services where the participant is located and is not limited to the participant's own home or private residence of a respite care worker.

Providers	**1. Respite Services due to COVID-19** a. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (B-3). NOTE: Requests for respite above the annual limit of 760 hours will not require an Exceptions Review but will require approval by the case management supervisor. **2. Location of Respite Services** a. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (B-3). i. Documentation during the COVID-19 emergency period must also include the reason(s) why services were delivered at an alternate location.
References: Waiver Appendix C1/C3, Standards (B-3) Section 3.13	

Service Definition/Limits – Specialized Medical Equipment and Supplies (SMES)	
Appendix K Flexibilities: Include as a covered SMES for the participant, personal protective equipment (PPE) and infection control supplies when not otherwise covered in the Medicaid state plan	
Operational Guidance	
Case Management	CM may approve the purchase of PPE and infection control supplies not covered in the Medicaid state plan during the emergency. CM must document in the ISP the need for PPE and infection control supplies. The Unit Supervisor and Section Supervisor shall authorize this service. 1. CM will give a verbal or email authorization to the provider to proceed with purchasing SMES. The final amount to be authorized retroactively in INSPIRE. 2. The provider will inform the CM when SMES has been purchased or procured and the total cost. a. If a purchase is made for multiple participants, the provider must calculate total cost per participant and inform the appropriate CM(s) accordingly. 3. SMES is authorized as $1.00 = 1 unit. Purchase amount per participant is rounded to the nearest dollar and authorizations are in whole units as follows: a. Purchase ends in $0.01 to $0.50 = Authorization is 0 units b. Purchase ends in $0.51 to $0.99 = Authorization is 1 unit c. Example: if the provider purchased $50.51 in infection control supplies, the CM would authorize 51 units of SMES. 4. The maximum allowed purchase cost is limited to no more than $300.00 per quarter. a. CM will use a fiscal year quarter (Jan – Mar, Apr – June, etc.). b. If the participant has exceptional needs due to the participant or member of the household having a positive test or presumptive positive for COVID-19, the CM Section Supervisor may approve PPE and infection control supplies above the limit. NOTE: CM will not be required to obtain denials from other insurance or state plan or be required to obtain a prescription from the participant's physician during the emergency.
Providers	For any provider interested in adding SMES to their approved list of services, CRB will work with the providers to become a qualified waiver provider for SMES. SMES must be purchased by a qualified waiver provider on behalf of the participant. 1. The flexibility in Appendix K permits the use of SMES to purchase infection control supplies and personal protective equipment (PPE) for participants, provider staff and natural supports to use during waiver-related activities with the participant. Examples of PPE may include masks, gloves or other items. Examples of Infection control supplies may include hand soap, hand sanitizer, paper towels, household disinfectant wipes or cleaners, etc. a. Infection control supplies and PPE purchased through SMES are for use in the immediate area while working with the participant. SMES is not intended for purchasing supplies used for general household cleaning or for purchasing PPE

that is not necessary for working with the participant during waiver-related activities.

b. The Centers for Disease Control (CDC) has many resources that providers and staff can reference on the use of PPE, proper hand hygiene, and disinfectants that are effective against the coronavirus that causes COVID-19. Some suggested sites include:
   - "How to Protect Yourself and Others" https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html
   - "CDC General Recommendations for Routine Cleaning and Disinfection of Households" https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html
   - "Use of EPA Registered Disinfectants" https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Service Authorizations:
Refer to the Case Management section above for details.

Procuring SMES:
1. On approval by CRB to add SMES to the provider's authorized array of services, the provider may begin working with participants, families/guardians and CMs.
2. Providers are expected to be cost-effective and prudent in the use of Medicaid funds to purchase PPE and infection control supplies, e.g. paying fair market values and being attentive to potential price gouging.
3. Infection control supplies and PPE approved by the CM, may be purchased through any source, such as retail, internet, or wholesale. Supplies and PPE may also be procured through donations, such as the Resilience Hub or other charitable organizations. Providers can also submit requests for PPE and supplies through the Behavioral Health and Homelessness Statewide Unified Response Group (BHHSURG) Resilience Hub. See request form at http://go.hawaii.edu/ODA.

Documentation Requirements:
1. The provider must keep the original receipt(s) and maintain itemized records for each participant.
   a. If a purchase is made for multiple participants, the provider must calculate and document the total cost for each participant.
2. Itemized records must include the following documentation:
   a. Name of the participant
   b. List of the specific PPE and/or supplies that were purchased for that participant
   c. Total cost of each purchase
   d. Date of purchase
   e. Date that the PPE and/or supplies were given to the participant
   f. Verification that the participant received PPE/supplies (e.g. confirmation signature or email from the participant or family/guardian)

Billing Instructions:
1. The provider can bill the total cost of the SMES for each participant, including General Excise Tax (GET) and shipping costs, if applicable.

	2. If a purchase was made for multiple participants, the provider shall calculate total cost per participant and bill accordingly. 3. The provider is reminded that only the actual costs incurred can be billed to the Medicaid waiver, regardless of the amount authorized. For example, if the authorized amount is $50.00 (50 units) but the provider was only able to purchase $35.00 (35 units), the provider can only bill for the $35.00 expended. 4. Do not bill to the Medicaid I/DD waiver if items were donated, rather than purchased. 5. Do not bill to the Medicaid I/DD waiver if the items purchased were not for the participant and ~~provider~~ staff ~~or natural support~~ to use during waiver-related activities.
References: Waiver Appendix C1/C3, Standards (B-3) Section 3.15	

SERVICE PLAN

ISP Process	
Appendix K Flexibilities: 1. The State may modify timeframes or processes for completing the Individualized Service Plan (ISP) as described in a) and b) below. a. Adjustments to the ISP may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly related to COVID-19 impacts. b. The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Services may start while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include the date reflecting the ISP meeting date.	
Operational Guidance	
Case Management	1a. Case managers may retroactively authorize services when Appendix K applies to service requests. i. The provider must contact the case manager to discuss the service needs related to COVID-19. ii. When it is determined that the request is related to COVID-19, the case manager will enter the service authorization through Inspire retroactively. Services may be retroactively authorized from March 1, 2020. 1b. The case manager will offer the participant and/or legal guardian a choice to use electronic signature or to receive a mailed ISP Consent for Services form. i. Authorized services may start while waiting for the participant and/or legal guardian's signature. ii. Date on the form must be the date of the ISP meeting and not when the form was signed.
Providers	Providers continue to be important members of the circle at the participant's ISP. ISP meetings may be done through telehealth. 1a. ISPs with retroactive approval dates for services may be needed to mitigate harm or risk directly related to COVID-19 impacts. The provider may begin delivering the service after receiving verbal or an email authorization from the CM, while the CM is waiting for the signature of the participant or legal guardian (even without the prior authorization). 1b. The provider must verify that the authorization is in Department of Human Services' Medicaid Online (DMO) before submitting any claims/billing.
References: Waiver Appendix D, Standards (B-3) Section 1.5	

Individual Supports Budgets	
Appendix K Flexibilities: Grant exceptions to the individual budget limits described in Appendix C-4 when needed to accommodate changes in service availability for a variety of circumstances that may arise from COVID-19	
Operational Guidance	
Case Management	CMs will not be required to submit an exceptions request if services exceed the individual supports budget due to the change in service availability, except when requests are made that are unrelated to the flexibilities in Appendix K. For example, requests for enhanced staff ratio (2:1 or 3:1) and enhanced supports (24/7 waiver services) will require an exceptions review, including review by CIT.
Providers	N/A
References: Waiver Appendix C-4, Standards (B-3) Section 1.5B	

TELEHEALTH

Use of Telehealth	
Appendix K Flexibilities: 1. These services may be provided through telehealth that meets privacy requirements when the type of supports meets the health and safety needs of the participant: • Adult Day Health (ADH) • Personal Assistance/Habilitation (PAB) • Individual Employment Supports (IES) • Discovery & Career Planning (DCP) • Training & Consultation • Waiver Emergency Services – Emergency Outreach 2. Case Managers may use telehealth that meets privacy requirements in lieu of face-to-face meetings to conduct Individualized Service Plan (ISP) meetings, assessments, individual monitoring and check-ins.	
Operational Guidance	
Case Management	The only service included in the six (6) Appendix K services above that can be consumer-directed (CD) is PAB. CD PAB may be delivered individually (1:1) or groups of one worker to two (1:2) or three (1:3) participants. Refer to Consumer-Directed Guideline for information. **Request for Services via Telehealth** 1) CM will discuss with participant, family/guardian, and service provider to determine if telehealth may be an option for service delivery. 2) If the participant requests telehealth services, the provider will complete the Telehealth Assessment tool. 3) If the participant is able to receive telehealth services, the provider will submit the Telehealth Assessment to the case manager via fax or email. 4) Upon request to email the Telehealth Assessment, the CM will initiate a secure email with the provider to submit the form electronically. Instructions on how to email PHI documents is found in Attachment B of the DDD 1915(c) Appendix K Operational Guidelines, v1, 3/30/20. 5) Upon receipt of the Telehealth Assessment by fax or email, the CM will review and discuss the responses with the provider. 6) The case manager can ask for additional information from the provider as necessary. **Service Authorization** 1) The case manager and provider will discuss the ISP Action Plan (COVID-19) to identify telehealth as a method for the provider to deliver services. The frequency of assessed support needs through telehealth will be confirmed with the participant and/or family/guardian. 2) CM will create a new action plan to reflect the change in service delivery and authorized hours. The ISP Action Plan (COVID-19) will document the following: "The addition of _____ service delivered through telehealth effective _____ is temporary, time limited for the duration of declared emergency, and will end when the state of emergency

	ends. The change in service is based on the participant's assessed need during the emergency." 3) Verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary. 4) See Appendix A decision tree for ADH/CLS-G or CLS-I to determine the appropriate service. The ISP Action Plan (COVID-19) must document the following: "The change in service from _____ to _____ effective _____ is temporary, time limited for duration of declared emergency , and will end when the state of emergency ends. The change in service is based on the participant's assessed need during the emergency."
Providers	1. **Services Provided Through Telehealth** The six (6) waiver services listed in Appendix K Flexibilities are direct services that are typically delivered face-to-face, with the exception of Individual Employment Services – Job Development. Appendix K specifies the broad service category. Some services have component parts or can be delivered individually or in groups. • ADH and PAB may be delivered individually (1:1) or in a group • A registered behavior technician (RBT) can deliver ADH 1:1 and PAB 1:1 • DCP includes direct services with the participant as well as Benefits Counseling • IES includes both Job Coaching and Job Development **A. <u>Criteria for the Use of Telehealth</u>:** The provider must demonstrate that all of the following criteria are met: 1) Each service requested is included in the Appendix K approved list. 2) The participant and family or legal guardian (if applicable) express interest in receiving services using telehealth. 3) The provider completes the Telehealth Assessment, to ensure the telehealth service meets the participant's needs and works with the Case Manager for telehealth authorizations. 4) The provider explains privacy requirements and documents in the participant's record that the participant and parent or legal guardian (if applicable) consented to the use of telehealth. 5) The provider and participant have the equipment to deliver and receive telehealth services that meets the participant's needs. 6) The provider attests that the participant and family/guardian have the choice to change from receiving services by telehealth to in-person when applicable. Social distancing and infection control must be practiced. **B. <u>Assessment for Appropriateness of Telehealth Services</u>** **Applies to ADH, PAB, IES, and DCP:** 1. Once the participant and family/guardian have expressed interest in receiving services using telehealth, the provider completes the <u>Telehealth Assessment Tables 1 & 2</u> (see Attachment B). a. The purpose of the assessment is to establish that the participant can benefit from telehealth services and the services are appropriate to meet

	the participant's needs based on the ISP outcomes and health and safety needs. b. The provider must specify the staff responsible for completing the assessment, typically the service supervisor. c. The staff completing the assessment must be familiar with the participant and family. d. The Telehealth Assessment must be completed for the initial request. If the participant requests or needs additional telehealth services or a change to an existing authorization, the provider must update the Telehealth Assessment form and re-submit to the Case Manager (CM). 2. The Telehealth Assessment should ideally be completed prior to starting or changing telehealth services or as quickly as possible if services were started to meet the participant's needs due to the COVID-19 emergency. 3. When the participant needs the worker to be physically present and/or to provide physical assistance to ensure the participant's health, safety and to meet habilitative needs, it is not appropriate to deliver the service via telehealth. For example, when a participant needs hands-on assistance, physical prompts or close stand-by assistance to perform activities of daily living, the service cannot be delivered via telehealth. 4. The provider must explain to the participant and family/guardian that receiving services through telehealth is a choice. If the participant and family/guardian decide to change from receiving services using telehealth to in-person services, the provider will work with the participant, family/guardian and CM to transition to in-person services, if applicable. **Applies to Training & Consultation:** 1. Once the participant and family/guardian have expressed interest in receiving services using telehealth, the provider completes the Telehealth Assessment Tables 1 & 3 (see Attachment B). a. The purpose of the assessment is to establish that the participant can benefit from telehealth services and the services are appropriate to meet the participant's needs based on the ISP outcomes and health and safety needs. b. The Telehealth Assessment must be completed for the initial request. If a new service is being requested for authorization to use telehealth at a future date, the Telehealth Assessment form must be updated and re-submitted to the CM. **Applies to Waiver Emergency Services – Outreach:** 1. Due to the nature of the service, responding to crisis calls may occur before the CM can authorize the service. a. The provider should follow existing protocols with the CM for authorizing services retroactively (after the crisis outreach service has occurred) b. Do not complete the Telehealth Assessment (see Attachment B).

C. **Service Authorization**:

1. The provider will submit the completed Telehealth Assessment to the CM by email or fax.
2. Refer to the Case Management section above for more information on the Service Authorization process.
3. The provider will respond within one business day to requests for additional information to support the request to use telehealth.

D. Service Delivery – Use of Telehealth:

Applies to ADH, PAB, IES, and DCP:

1. The provider is responsible to ensure that telehealth strategies and activities engage participants and broadly align with their ISP outcomes. Examples of general ISP outcomes that can be translated to telehealth activities are provided below for illustrative purposes only.
    - Skill Development —> video and practicing proper hand washing, healthy snack challenge with group discussion, verbal prompting for personal care support
    - Social Interaction —> lead discussion or activity on area of interest, coordinate activities such as virtual hangouts
    - Communication —> discuss a shared experience based on material presented, such as a virtual tour of a museum
    - Personal Interests —> virtual cooking class, making cards for family and friends
    - Physical Activity/Exercise —> staff-led video fitness class, virtual dance party
    - Community Resources/Experiences —> step-by-step how to order food online, traffic safety book and group discussion
    - Self-determination/self-advocacy —> learning about rights and responsibilities, mapping personal goals
    - Job Discovery/Career Planning —> creating a video resume
    - Employment —> role playing workplace conversations with coworkers and supervisors
2. Wellness check-ins may be a part of the service delivery but cannot comprise the entirety of the telehealth service.

Applies to Training & Consultation:

The provider will deliver services in accordance with Waiver Standards, licensing requirements and scope of practice.

Applies to Waiver Emergency Service – Crisis Outreach:

The provider will deliver services in accordance with the contract using telehealth in lieu of face-to-face visits when such a visit can meet the individual's health and safety needs.

E. Service Supervision – Use of Telehealth

Applies to All Waiver Services with Service Supervision Requirements (including those services that are not delivered using telehealth):

1. Monthly service supervision or quality assurance monitoring visits may be done using telehealth for all service delivery (i.e., service delivery through telehealth and traditional face-to-face).
    a. The provider must conduct and maintain documentation of supervisory or monitoring visits in accordance with the requirements in the Standards (B-3).

Applies to ADH, PAB, IES, and DCP:

1. In addition to documentation of supervisory or monitoring visit requirements in the Waiver Standards (B-3), the documentation must also demonstrate that the delivery and duration through telehealth, is appropriate and effective in meeting the participant's goals and outcomes.

F. **Telehealth Requirements**:

Applies to All Telehealth Services

1. For all direct services that would typically be delivered face-to-face, the priority approach would include technology with audio and video communication. When other technology is not available, the provider can use telephonic (audio only) communication.
2. The provider is responsible for ensuring the telehealth platform(s) being used are compliant with the Office of Civil Rights "Notification of Enforcement Discretion for Telehealth". https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
    a. The OCR "Notification of Enforcement Discretion for Telehealth" states: "covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype to provide telehealth".
        i. Per OCR, "Providers are encouraged to notify [patients] that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."
    b. OCR also identifies video communication applications that should not be used, including "Facebook Live, Twitch, TikTok and similar video communication applications that are public facing."
    c. The information in a. and b. above are intended as guidance and are not an exhaustive list. The provider must stay up-to-date and comply with privacy requirements and notifications related to the use of telehealth.

G. Documentation:

Applies to All Telehealth Services

1. The provider must complete and maintain service delivery documentation, records and reports in accordance with the requirements in the Standards (B-3).

	In addition, the following applies to ADH, PAB, IES, and DCP: 1. Documentation during the COVID-19 emergency period must also include the following: a. list the name(s) of the DSW who provided the service b. include the service date, start and end times of the telehealth service c. indicate if the service was individual (1:1) or group (the DSW engaged with more than 1 participant on the telehealth session). d. describe the support/activities provided to the participant(s) and participant(s) response (e.g., ability to engage or level of engagement) e. if the technology used is different from what was included on the Telehealth Assessment, document the technology used and reason. **H. <u>Billing Instructions</u>:** 1. The provider must only bill for the time (start and end times) of service delivery when: a. the DSW is actively engaging with the participant(s), i.e., this is not a passive service like remote monitoring; and b. the DSW is not engaged in other duties or activities when delivering telehealth support to a participant. 2. If a group activity is provided, the provider will maintain documentation that lists the names of all participants who received the service (attendance log or similar). This log is not kept in a participant record but is filed and available for audit purposes. 3. Rates & Code Changes for Telehealth a. The authorization for the service provided using telehealth will have the same code but with a unique telehealth modifier. The modifiers are included on the revised Master Rate Sheet (https://health.hawaii.gov/ddd/files/2020/04/Updated-IDD-Waiver-Rate-Sheet-COVID-19-Emergency.pdf). b. Telehealth for T&C EAA does not have a unique telehealth modifier and will **use Place of Service Identifier "02"** on claims to denote the use of telehealth.
References:	

ADVERSE EVENT REPORTING

Participant Safeguards – Adverse Event Reporting	
Appendix K Flexibilities: 1. Modify verbal and written timelines for reporting as deemed necessary by DOH-DDD and DHS-MQD (e.g., limiting the focus to the most critical adverse incident reports requiring both verbal and written notification). 2. Permit the case manager assessment and 24-hour face-to-face visits for instances of suspected abuse or neglect to be conducted using telehealth that meets privacy requirements unless an onsite assessment is deemed necessary by DOH-DDD. The DOH-DDD staff will be alert for potential evidence of abuse, neglect and exploitation through their remote strategies for oversight.	
Operational Guidance	
Case Management	**1. No modifications to verbal and written timelines. Only change is how the verbal and written reports are submitted.** a. Each Case Management unit must have a designated staff responsible for receiving incoming reports for adverse events (verbal and written when submitted by fax). b. Designated staff must notify the CM immediately when a verbal or written report is received. c. If the reporter is sending the AER via email, CM to assist with encrypting the email. For further details/instruction on email encryption, please refer to: https://health.hawaii.gov/ddd/files/2020/04/Provider-Instructions-Emailing-PHI-Documents.pdf. **2. Telehealth for face-to-face visits** a. CMs are required to conduct a face-to-face with the participant within 24 hours of receipt of a verbal report for events involving suspected abuse, neglect, or exploitation. CMs will be permitted to assess and conduct the face-to-face with the participant by telehealth. b. Any onsite assessment deemed necessary will be determined by the DDD Administrator, CMB Chief, OCB Chief, and Medical Director.
Providers	**1. No modifications to verbal and written timelines.** Providers must continue to report all adverse events to the CM within the required timelines as stated on page 48 – 51 of the Waiver Standards (B-3). The following are the temporary changes to the AER procedures that is only applicable during this public health emergency. **Changes to How Provider May Provide Verbal Notification and Written Report** 1. Verbal Notification a. Provide verbal report to the case management unit's main line within 24 hours or the next business day of the adverse event. b. Leave a voice message on the unit's main line, if reporter is not able to speak to the CM/unit staff. The voice mail must include the following information: • The participant's name • Date of the event • Type of event • Brief description of the event • Provider's contact information

	2. Written Submission a. Submit written report to the case manager within 72 hours of the adverse event by fax to: i. Case management unit's fax number; and ii. Outcomes and Compliance Branch (OCB) at 453-6585. b. Email AER, if unable to fax to: i. CM's email address; ii. CM's unit supervisor's email address; and iii. OCB at: mari.wakahiro@doh.hawaii.gov, • Send AER using HIPAA-compliant encryption. For further details/instruction on email encryption, please refer to: https://health.hawaii.gov/ddd/files/2020/04/Provider-Instructions-Emailing-PHI-Documents.pdf c. Sign Section D of the AER. If reporter is unable to sign, reporter must include a statement in the email that the reporter/provider attest that the information provided is true, accurate, and complete to the best of their knowledge. **Update on Adverse Events for Change in Health Condition Requiring Medical Treatment** 1. An adverse event must be generated and submitted to the Developmental Disabilities Division (DDD) under the category of Change in Health Condition Requiring Medical Treatment for the following COVID-19 related incidents: a. Participant has had direct contact with a person who tested positive for COVID-19; b. Participant was tested for COVID-19; and c. Participant tested positive for COVID-19. 2. If the incident was related to COVID-19 and did not require medical treatment as defined in the DDD Adverse Event Policy and Waiver Provider Standards, it must still be reported as an adverse event. Example: if the caregiver suspects that the participant is showing COVID-19 symptoms, follows up with the PMD who determines that s/he needs to get tested, sends the participant to get tested at a designated testing clinic, and the participant returns home while waiting for the results of the test an AER will need to be generated for this incident.
References: Waiver Appendix G, Standards (B-3) Section 1.8	

PROVIDER STAFF QUALIFICATIONS AND MONITORING

Provider Qualifications	
Appendix K Flexibilities: 1. Staff qualification requirements other than being 18 years of age and legally able to work in the United States (e.g., criminal history check, staff training, CPR and first aid certification, etc.) will be suspended during a declared public health emergency. 2. Providers may choose to provide training on-line in lieu of in-person training. Trainings may also be conducted by telehealth. Telehealth that meets privacy requirements must be used to conduct participant-specific training in the ISP.	
Operational Guidance	
Case Management	N/A
Providers	**1. Staff Qualification Requirements** Providers may choose to do a provisional hire for new staff who are unable to meet all the staff qualification requirements in Waiver Standards (B-3) during the COVID-19 emergency period. **Applies to provisional hire for new staff:** a. Mandatory requirements for a provisional hire for new staff during the COVID-19 emergency period include: i. At least age 18; ii. Able to work legally in the United States; iii. Not be named on the U.S. Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the Med-QUEST excluded provider list; iv. TB clearance issued within the past 365 days; v. Training in the participant's ISP and IP and possess the skills and knowledge to implement the plan(s); vi. Fieldprint fingerprinting and background checks NOTE: The provider may process a State Name Check (e-Crim) while Fieldprint results are still pending for the following reasons: ▪ the health and safety of a participant is at risk and need for immediate support staff ▪ staff is unable to schedule a Fieldprint appointment due to temporary site closure ▪ Fieldprint results are delayed past 1 week The provider must ensure that the evaluation of the e-Crim report findings must meet the requirements for hiring as outlined in the Med-QUEST Criminal History Record and Background Check Standards Section IV to allow the staff to begin service delivery while awaiting final Fieldprint results. Standards located at Med-QUEST website https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/Criminal-History-Record-Check-Standards.pdf b. The following requirements are at the discretion of the provider, but are not mandatory during the COVID-19 emergency period: i. High school diploma or equivalent

	ii. CPR and First Aid training iii. Required training topics – the provider may select modules for new staff orientation from the list of training topics in Waiver Standards (B-3) but are not required to include all topics before the staff begins providing services. c. The provider must maintain documentation of all provisional hires during the COVID-19 emergency period. Documentation must include the following: i. Name of staff ii. Position iii. Date started providing services iv. Date stopped providing service, if applicable, including the reason(s) v. List of requirements in Waiver Standards (B-3) that were waived or suspended due to the COVID-19 emergency vi. Attestation to the following, if Fieldprint fingerprinting and background checks are pending: • The staff met all other the mandatory requirements for provisional hire, including the State Name Check e-Crim; • The staff is unable to complete or is experiencing delays in receiving results of the Fieldprint fingerprinting and background checks, including the reason(s); • The provider is choosing to allow the staff to begin providing services while results of the Fieldprint fingerprinting and background checks are pending; • The provider will immediately remove staff from providing direct services when the Fieldprint results in a "red light" for that staff. **Applies to current staff:** a. Mandatory requirements for current staff include: i. At least age 18 ii. Able to work legally in the United States iii. Not be named on the U.S. Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the Med-QUEST excluded provider list. iv. State Name Check e-Crim, if applicable according to Waiver Standards (B-3) v. Trained in the participant's ISP and IP and possess the skills and knowledge to implement the plan(s). vi. Annual Fieldprint fingerprinting and background checks NOTE: If staff is unable to complete or experiences delays in receiving results of the Fieldprint fingerprinting and background checks due to the COVID-19 emergency, the provider must document the status and reason(s). b. The following requirements are at the discretion of the provider, but are not mandatory during the COVID-19 emergency period: a. High school diploma or equivalent b. TB clearance

	c. CPR and First Aid training d. Required training topics – the provider may select modules for continuing education for staff from the list of training topics in Waiver Standards (B-3), but are not required to include all mandatory topics during the COVID-19 emergency period. **Applies to all staff (current and provisional hires):** a. Staff qualification requirements will revert to the requirements in Standards (B-3), Section 2.2 after the COVID-19 emergency period ends. Post-emergency, providers will be responsible to ensure all staff fulfill requirements that were waived or suspended during the COVID-19 emergency period. 2. **Training On-line in Lieu of In-Person Training** a. Providers may choose to provide staff training on-line or by telehealth in lieu of in-person training.
References: Waiver Appendix C1/C3, Standards (B-3) Section 2.2	

Quality Assurance – Provider Monitoring	
Appendix K Flexibilities: Annual on-site provider validations and reviews for quality management, performance measure reporting, and financial audits may be delayed or cancelled during the declared public health COVID-19 pandemic. Reviews by desk audit or other methods may be used as deemed appropriate by DOH-DDD.	
Operational Guidance	
Case Management	N/A
Providers	a. Provider monitoring visits or reviews by desk audit originally scheduled to occur within the effective timeframe of the Appendix K for the COVID-19 emergency, will be cancelled or rescheduled. b. Providers will receive an email from CRB, notifying them of the status of their monitoring visit or review by desk audit. c. If the monitoring visit or review by desk audit was completed prior to the COVID-19 emergency, providers may continue to submit their Corrective Action Plans (CAP) to CRB via fax or mail. d. If a provider is unable to submit their CAP due to the COVID-19 emergency, they must contact CRB to request an extension.
References: Waiver Appendix C QIS, Standards (B-3) Section 2.9	

REDETERMINATIONS

Process for Level of Care	
Appendix K Flexibilities: 1. Level of care annual redeterminations may be extended for up to one year past the due date of the approved DHS1150-C during the declared public health COVID-19 pandemic.	
Operational Guidance	
Case Management	1. Level of care annual redeterminations may be extended up to 365 days from the previous determination date during the declared public health COVID-19 pandemic. 2. The extension may be due to the participant not being able to complete a physical exam during the public health COVID-19 pandemic. The participant will be scheduled for a physical examination/evaluation at the end of the public health COVID-19 pandemic.
Providers	N/A
References: Waiver Appendix B-6-f, Standards (B-3) Section 1.4.A	

RETAINER PAYMENTS

Retainer Payments

Appendix K Flexibilities:

Residential Habilitation:

~~DDD will make~~ Retainer payments can be made to Residential Habilitation providers when an individual is absent from the home for more than 21 days in the plan year, for any reason, to ensure the individual retains their placement in their home and to provide financial certainty for providers during the COVID-19 pandemic when participants are more likely to experience absences. Such retainer payments will be limited to ~~the lesser of~~ 30 consecutive days ~~or the number of days for which Hawaii authorizes similar payments in nursing facilities~~.

Adult Day Health (ADH), Community Learning Services – Group (CLS-G), Individual Employment Supports – Job Coaching (IES-JC):

Retainer payments can be made when authorized for ADH, CLS-G, and IES-JC in order to preserve shared day service programs and employment programs that may not be able to deliver services during the COVID-19 pandemic. The retainer payments will be a billed monthly based on unit of service equal to the difference between 90 percent of a provider's billing for a given participant in a baseline period and billing for services actually provided each month of the declared public health emergency. Such retainer payments must meet the conditions in these guidelines and will be limited to 30 consecutive days. (Full description can be found in Appendix K-2-j, amendment #2, approved 5/5/20.)

Personal Assistance/Habilitation – Consumer Directed (CD PAB):

~~DDD will make~~ Retainer payments can be made, when authorized, to consumer-directed workers for the ~~authorized hours~~ number of hours the employee typically works, not to exceed 40 hours per week, when the participant they serve is unable to receive services. Such retainer payments will be limited to ~~the lesser of~~ 30 consecutive days ~~or the number of days for which Hawaii authorizes similar payments in nursing facilities~~.

Operational Guidance

Case Management	**Residential Habilitation (ResHab)** ResHab retainer payments are established to ensure that participants have a home to return to after an extended period of absence. ResHab retainer payments are established to assist ResHab providers during the COVID-19 emergency period, when participants are more likely to experience absences. Authorization No separate authorization will be needed for ResHab retainer payments. Providers will bill retainer payments against an individual's existing ResHab authorization. **Adult Day Health (ADH), Community Learning Services – Group (CLS-G), Individual Employment Supports – Job Coaching (IES-JC)** Authorization: *NOTE: The case manager will not need to input the authorizations for retainer payments for ADH, CLS-G, IES-JC. These authorizations will be imported into INSPIRE.* For more information, refer to the Provider Section of this guideline where the methodology for calculating retainer payments is described.

	Personal Assistance/Habilitation – Consumer Directed (CD PAB) Refer to Consumer Directed Operational Guidelines
Providers	**Residential Habilitation (ResHab)** ResHab retainer payments are established to ensure that participants have a home to return to after an extended period of absence during the COVID-19 emergency. ResHab retainer payments are established to assist ResHab providers during the COVID-19 emergency period, when participants are more likely to experience absences. 1. ResHab retainer payments apply, during the emergency period, when a participant exceeds the 21 days of absence already funded through the ResHab rates in the participant's plan year. For example, during the emergency period a participant reaches a total of 34 days of absence during the plan year, the provider can bill the retainer for 13 days (34 days minus 21 days). a. Providers can bill the retainer payment for a participant's absences, above 21 days, retroactive to March 1, 2020. b. Retainer payments will be in effect until the end of the declared emergency period. c. Total days billed for ResHab and ResHab retainer payments cannot exceed the maximum of 344 days per the participant's plan year. 2. ResHab retainer payments are equal to the existing ResHab rates. Authorization No separate authorization will be needed for ResHab retainer payments. Retainer payments will be billed against the existing ResHab authorization. Billing Instructions 1. Providers may bill for a retainer payment for absences that occur during the declared public health emergency after the participant has had 21 absences in their current plan year (that is, there must be 21 days in the participant's plan year during which ResHab has not been billed before a retainer payment is billed because 21 absences are built into the rate). The participant must be expected to return to the home. a. After a participant has been absent for more than a total of 21 days in their plan year, the provider can begin billing the retainer payment. b. If the participant already has 21 absences during their plan year, the provider can begin billing the retainer immediately, retroactive to March 1, 2020, for any additional days of absence. c. Retainer payments will only be paid for absences that occur during the declared public health emergency. Any retainer payment claim for a date of service occurring before March 1st or after the last day of the declared public health emergency will be denied. d. By billing for a retainer payment, the provider is attesting that the claim meets the requirements of this section. 2. Providers will bill for retainer payments the same as billing for regular ResHab services but **must include "99" in the Place of Service field**. All other procedure codes and modifiers remain the same.

3. DDD will conduct post-emergency audits of retainer payments. Any payments that are made that do not comply with the provisions of the Billing Instructions will be recouped.

Adult Day Health (ADH), Community Learning Services – Group (CLS-G), Individual Employment Supports – Job Coaching (IES-JC)

ADH, CLS-G, and IES-JC retainer payments are established to support a stable provider network and workforce during a period in which providers are unable to provide the volume of services they have historically delivered. The retainer payments are established to assist providers to retain staff, during the COVID-19 emergency period, when there is likely to be a reduction of these services.

1. ADH, CLS-G, and IES-JC retainer payments apply, during the emergency period, for providers that have not reduced aggregate wages for direct support workers (DSWs) of these services by more than 25 percent during the month for which the provider submits for a retainer payment.
    a. The 25 percent reduction limitation only applies to DSWs who typically provide ADH, CLS-G, and IES-JC services, as applicable.
    b. Providers can bill the retainer payments retroactive to March 1, 2020.
    c. If providers have previously reduced DSWs' pay by more than 25 percent, they cannot bill for months in which they fell below that threshold. If they recall staff, they may begin billing the retainer payment.
    d. DDD intends to evaluate compliance with the requirement by comparing wages paid to staff during the payrolls occurring during the month for which a retainer is being claimed to wages paid in January and February 2020. This will be calculated by:
        i. Summing total staff wages paid for payrolls in January and February
        ii. Dividing these totals by the number of payrolls to calculate a per-payroll average
        iii. Comparing this threshold to the payrolls occurring during the month for which a retainer was claimed

2. Retainer payments will be in effect until the end of the declared emergency period.
3. The retainer payments are limited to 90 percent of the difference between the average amount billed during a baseline period to the actual amount of service billed in the month for which the retainer is being claimed

Authorization:

1. For each existing ADH, CLS-G, or IES-JC authorization, DDD will calculate the average amount billed during a baseline period.
    a. DDD will total paid claims for the applicable service for the months of October through December 2019 and will divide that total by the number of months during this period in which the participant received one or more units of the applicable service.
        i. For example, if a provider billed $800 of ADH for a participant in October and $600 in November, the average amount billed would be $700 ($800 + $600 divided by 2 months).
    b. DDD will report to case managers and providers the calculated average amount billed during the baseline period.

2. The average monthly amount billed during the baseline period will be multiplied by 90 percent, which is the amount that will be authorized by DDD for retainer payments.
    a. Limiting the retainer to 90 percent of the lost billing is intended to account for certain reductions in provider expenses (such as reduced utility or mileage costs) and to ensure that billing does not exceed the equivalent of 30 consecutive days.
    b. Based on the example above, the retainer authorization for ADH would be $630 per month ($700 multiplied by 90%).
3. The retainer authorization amount will be imported into INSPIRE and reported to the provider as the authorization for retainer payments.

NOTE: This is *not* necessarily the amount to be billed because providers still must account for the services they are providing as discussed in the Billing section.

4. Retainer payments have unique codes for ADH, CLS-G, and IES-JC. The codes are included in the revised Master Rate Sheet (https://health.hawaii.gov/ddd/files/2020/04/Updated-IDD-Waiver-Rate-Sheet-COVID-19-Emergency.pdf)
5. Retainer rates are authorized as $1.00 = 1 unit. The units/dollar amount entered by the provider is calculated as 90 percent of the difference between the average amount billed during a baseline period to the actual amount of service billed in the month for which the retainer is being claimed. Unit/dollar amounts per participant is rounded to the nearest dollar. Authorizations and claims are in whole units as follows:
    a. Authorization/claim ends in $0.01 to $0.50 = Authorization/claim is 0 units
    b. Authorization/claim ends in $0.51 to $0.99 = Authorization/claim is 1 unit

Billing Instructions:

1. Providers may bill for retainer payments for 90 percent of the difference between the average amount billed during a baseline period to the actual amount of service billed in the month for which the retainer is being claimed.
    a. Providers will first determine the amount they billed for services actually provided during the month.
    b. Billing for services actually provided will then be subtracted from the baseline amount, calculated by DDD, for that participant and service. Providers may bill for 90 percent of the difference calculated.
        i. For example, if a provider previously billed ADH for a participant at the baseline amount of $700 and actually provided $200 in the current month, the difference between the baseline amount and the actual billing is $500 ($700 - $200). The provider may bill the retainer for $450 ($500 multiplied by 90%).
    c. The provider will include the dates in the month minus the last day of the month (e.g. 3/1/2020 - 3/30/2020) on the claim, as to not exceed the 30 consecutive day limit.
2. Providers may not bill a retainer payment for any month during which they have reduced the aggregate wages for direct support worker's by more than 25 percent.
    a. By billing for a retainer payment, a provider is attesting that they have not reduced aggregate wages for direct support workers by more than 25 percent

	b. This requirement only applies to direct support workers who typically provide ADH, CLS-G, and IES-JC services, as applicable. 3. Any payments that are made, but that do not comply with the provisions of the Billing Instructions – such as billing for a retainer that exceeds 90 percent of the difference between the baseline amount and actual services billed – will be recouped. **Personal Assistance/Habilitation – Consumer Directed (CD PAB)** Refer to Consumer Directed Operational Guidelines
References: Waiver Appendix I, Standards (B-3) N/A	

OTHER WAIVER REQUIREMENTS

Waiver Requirement for a Minimum of One Service Per Month	
Appendix K Flexibilities: Allow participants to receive less than one waiver service per month for a period of 120 days without being subject to discharge. The case manager will provide monthly monitoring to ensure the plan continues to meet the participant's needs. Monitoring may be done using telehealth that meets privacy requirements.	
Operational Guidance	
Case Management	To be updated
Providers	DDD has received approval to extend the length of time a participant may remain enrolled in the waiver if they get either 1) a service or 2) a case management monitoring contact every month. The same expectation applies to providers that must not discharge a participant from their services for a period of 120 days, even if the participant is not receiving any services from the provider during that time. a. Before discharging a participant who has not received a service for 120 days, the provider must notify the case manager and CRB. b. A provider may only discharge a participant who continues to be enrolled in the waiver at the participant or legal guardian's choice.
References: Waiver Appendix B-6	

HCBS Final Rule	
Appendix K Flexibilities: 1. In order to limit the transmission of COVID-19, suspend requirements for allowing visitors (providers may prohibit/restrict visitation in-line with CMS recommendations for long term care facilities) and for individuals' right to choose with whom to share a bedroom. 2. The I/DD waiver program will adhere to all local, state and federal requirements for social distancing and other approaches to limit transmission of COVID-19. These limits do not require modifications to the ISP during the declared public health emergency. Other limits not required by the COVID-19 pandemic will be addressed through the ISP process.	
Operational Guidance	
Case Management	N/A
Providers	The provider is expected to maintain regular communication with their ResHab providers/workers about the approaches being used to ensure health and safety, as well as social distancing.
References: Waiver Appendix Attachment #2, Standards (B-3) Section 3.12	

Attachments for Appendix K

Attachment A: Choosing Services Decision

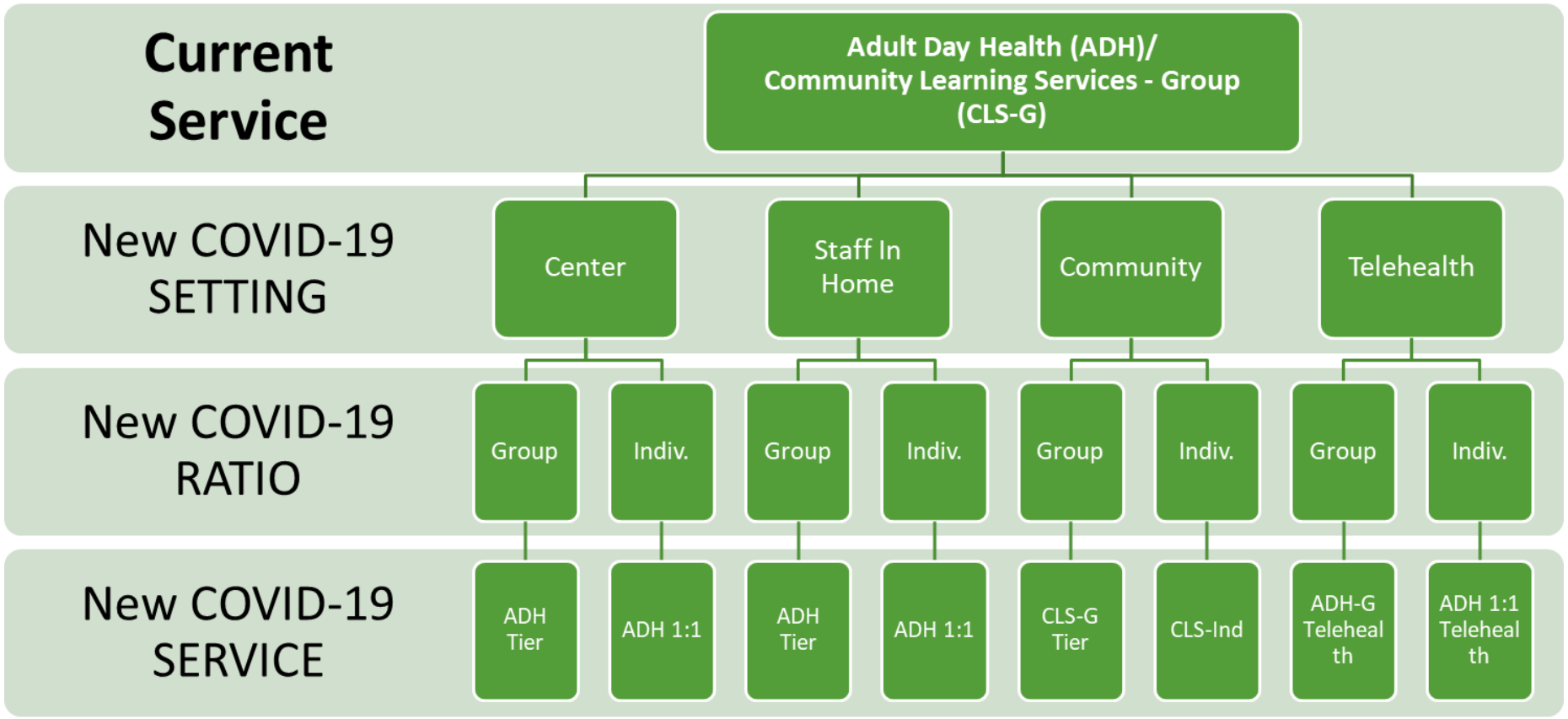
These decisions trees are intended to provide a crosswalk of potential changes to authorized services based on changes to how services are delivered during the Covid-19 emergency.

To determine the appropriate 'new' service, the decision trees walk-through three facts:

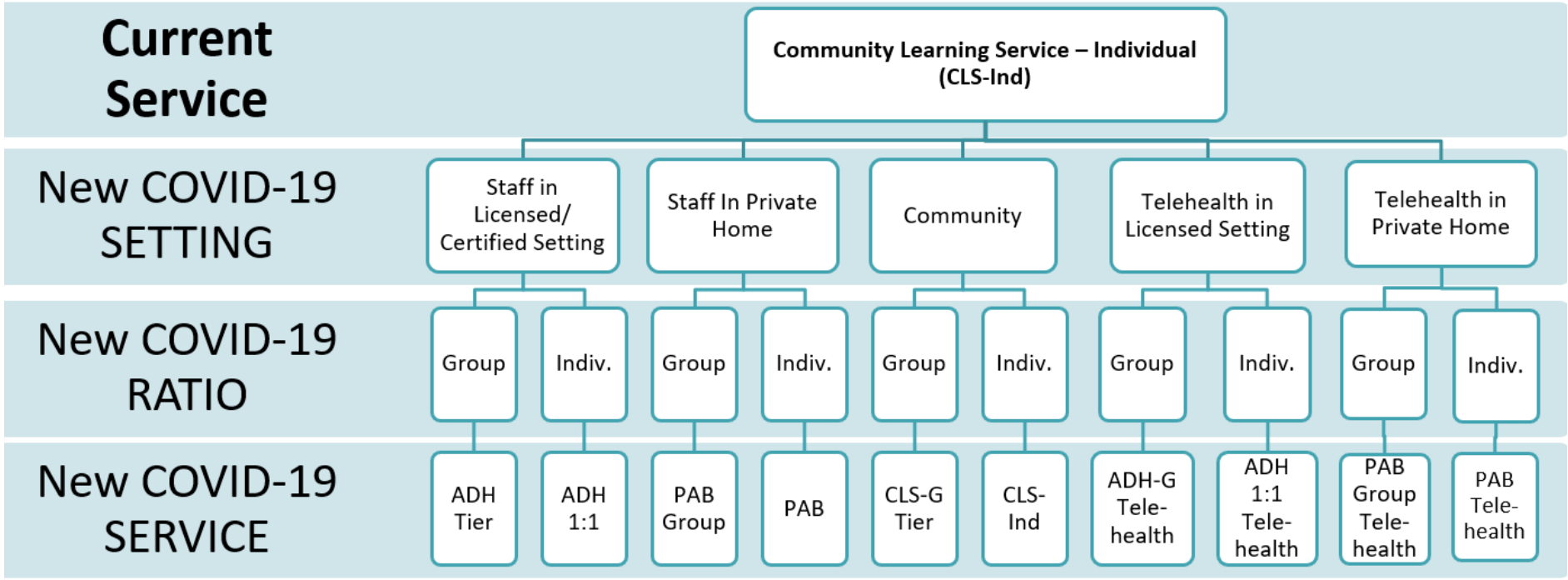
1. What is the current service?
2. Where will the service be delivered during the covid-19 emergency?
3. What is the staffing ratio? (either one-to-one or group if delivered to two or more participants

The resulting 'new' service represents the general approach that will be followed to determine the new service, but there may be exceptions

Decision Tree: Adult Day Health (ADH)/Community Learning Services-Group (CLS-G)



Decision Tree: Community Learning Services (CLS-Ind)



Attachment B: Telehealth Assessment for Use During Covid-19 Emergency

1915(c) Home and Community Based Medicaid Waiver
for Individuals with Intellectual and Developmental Disabilities

Participant Name	
Provider Agency	
Name & Title of Agency Staff completing the form	
Agency Staff Contact Phone & E-mail	
Date Completed	

TABLE 1. SERVICE(S)* VIA TELEHEALTH *(check all that apply):*

Service	Requested HOURS	Specify per DAY, WEEK, or MONTH
☐ Adult Day Health (ADH)		
☐ 1:1		
☐ Small Group		
☐ Personal Assistance/Habilitation (PAB) including CD		
☐ 1:1		
☐ Small Group		
☐ Individual Employment Supports (IES)		
☐ Job Coaching		
☐ Job Development		
☐ Discovery & Career Planning (DCP)		
☐ DCP - Benefits Counseling		

** See Table 3 for Training & Consultation, Waiver Emergency Services - Outreach*

TABLE 2. ASSESSMENT OF APPROPRIATENESS FOR SERVICES

Instructions: When requesting multiple services via telehealth, the responses to the following questions must be TRUE for all services. If the response for any service is FALSE, that service cannot be delivered via telehealth and should not be checked in Table 1. This assessment must include all requested services the participant will receive from the provider completing the assessment.

TRUE	FALSE	PARTICIPANT ENGAGEMENT
☐	☐	1. The participant can engage in the service(s) without needing the worker to be physically present and/or to provide physical assistance to ensure the participant's health and safety and to meet habilitative needs.
☐	☐	2. The participant can engage in the service(s) independently, with verbal/ visual cues and prompts, or with willing and available natural supports.
☐	☐	3. The participant can generally engage in activities via telehealth for sufficient time to benefit from the activities.

TRUE	FALSE	PARTICIPANT ENGAGEMENT
☐	☐	4. The service(s) via telehealth can meet the participant's health, safety, and habilitative needs. Briefly describe how: _____ _____
☐	☐	5. The service(s) via telehealth includes strategies and activities that align with the participant's ISP outcomes in the following broad areas: ☐ Skill Development ☐ Community Resources/Experiences ☐ Social Interaction ☐ Self-Determination/Self-Advocacy ☐ Communication ☐ Job Discovery/Career Planning ☐ Personal Interests ☐ Employment ☐ Physical Activity/Exercise ☐ Other: _____
☐	☐	6. The provider attests that the participant and family/guardian have the choice to change from receiving services by telehealth to in-person when applicable.
☐	☐	7. The participant has the materials needed for any activities (if applicable). This can be supplied by the provider or by the participant/family if using common household items that do not require special out-of-pocket expenses for the participant and family. If infection control supplies are required during waiver activities, the provider can use SMES to purchase those infection control supplies. Leave blank if N/A.

TRUE	FALSE	TELEHEALTH CAPACITY
☐	☐	8. The participant has the telehealth equipment required for the service(s) (check all that will be used): ☐ Telephone ☐ Computer, tablet or smart phone ☐ Internet with sufficient bandwidth to support audio/video conferencing ☐ Other technology: _____
☐	☐	9. The provider has the telehealth equipment required for the service(s).
☐	☐	10. The participant can use the telehealth equipment. This may include independent use, assistance for set-up and troubleshooting by willing and available natural supports, or remote technical assistance from the provider.

TRUE	FALSE	PRIVACY
☐	☐	11. The provider is using technology that is non-public facing and compliant with the Office of Civil Rights "Notification of Enforcement Discretion for Telehealth". https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
☐	☐	12. The provider has explained privacy requirements for telehealth service delivery and has obtained and documented permission from the participant or legal guardian.

TABLE 3: TRAINING & CONSULTATION

Service	Requested HOURS	Specify unit (DAY, WEEK, MONTH)
☐ Training & Consultation		
☐ Behavior Analyst		
☐ Psychologist		
☐ Registered Nurse		
☐ All Other Therapist (OT, PT, Speech, Family, Dietician)		
☐ Environmental Accessibility Adaptations		

TRUE	FALSE	PARTICIPANT ENGAGEMENT
☐	☐	1. Assessment - The participant can engage in the assessment independently or with physical assistance from natural supports or waiver staff while the T&C therapist conducts the telehealth assessment.
☐	☐	2. The service is within the scope of practice and license of the T&C therapist.
☐	☐	3. Supervision and Oversight of Plans – The participant and natural supports/DSWs can participate in the supervision session using telehealth.
☐	☐	4. The provider can provide in-person T&C based on the needs of the participant, while maintaining social distancing and infection control practices.

TRUE	FALSE	TELEHEALTH CAPACITY
☐	☐	5. The participant has the telehealth equipment required for the service *(check all that will be used):* ☐ Telephone ☐ Computer, tablet or smart phone ☐ Internet with sufficient bandwidth to support audio/video conferencing ☐ Other technology: _____
☐	☐	6. The provider has the telehealth equipment required for the service.
☐	☐	7. The participant can use the telehealth equipment. This may include independent use, assistance for set-up and troubleshooting by willing and available natural supports, or remote technical assistance from the provider.

TRUE	FALSE	PRIVACY
☐	☐	8. The provider is using technology that is non-public facing and compliant with the Office of Civil Rights "Notification of Enforcement Discretion for Telehealth". https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
☐	☐	9. The provider has explained privacy requirements for telehealth service delivery and has obtained and documented permission from the participant or legal guardian/personal representative (if applicable).

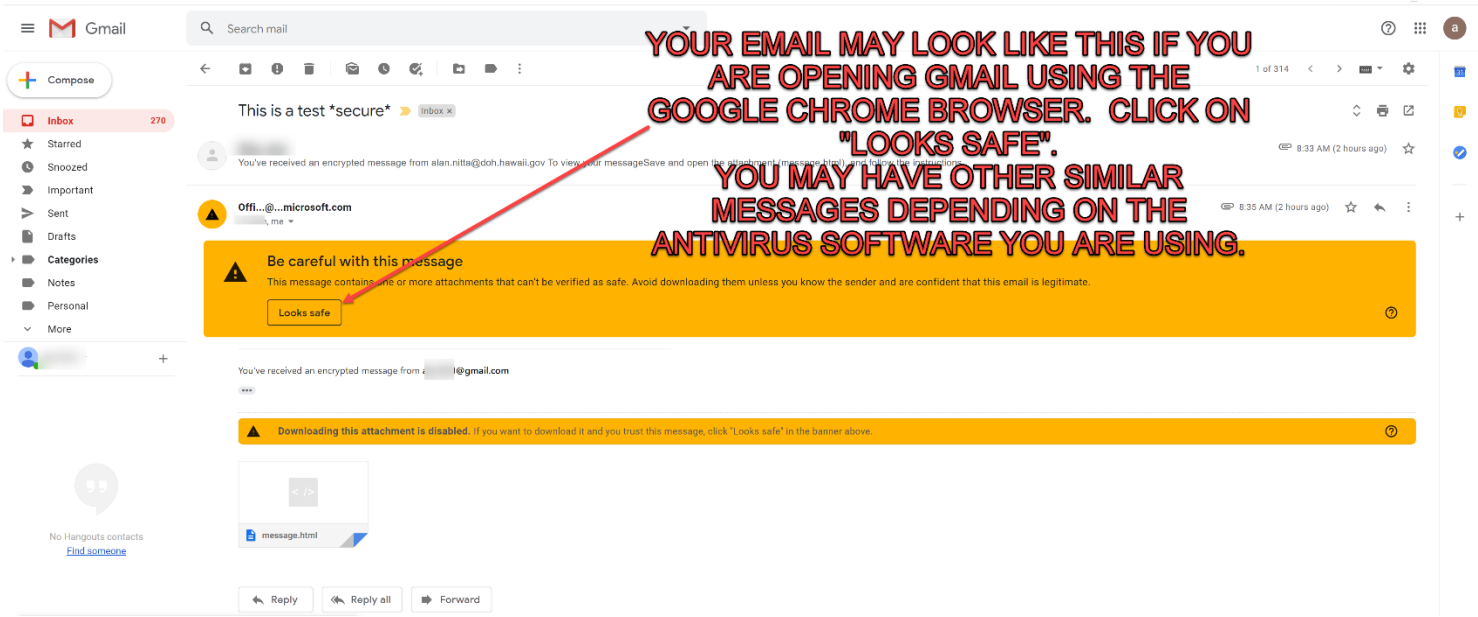
Attachment C: Encrypted E-mails

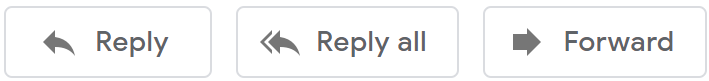
PROVIDER INSTRUCTIONS ON EMAILING PHI DOCUMENTS

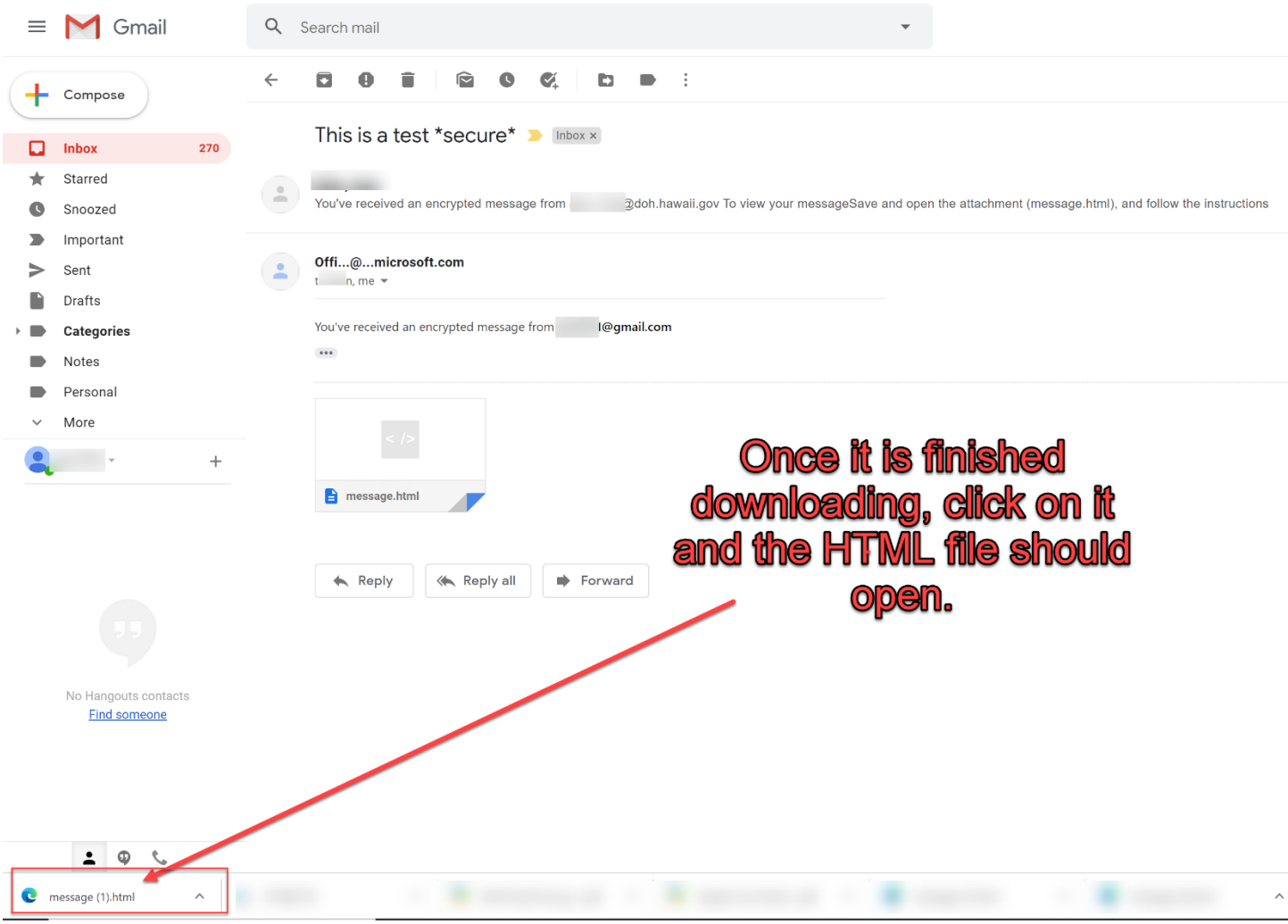
3/30/2020

1. Call your Case Manager and ask them to send you a *secure* email. The email will look like the one below. **If you double click and the html file opens, please skip to #3 in the instructions.**

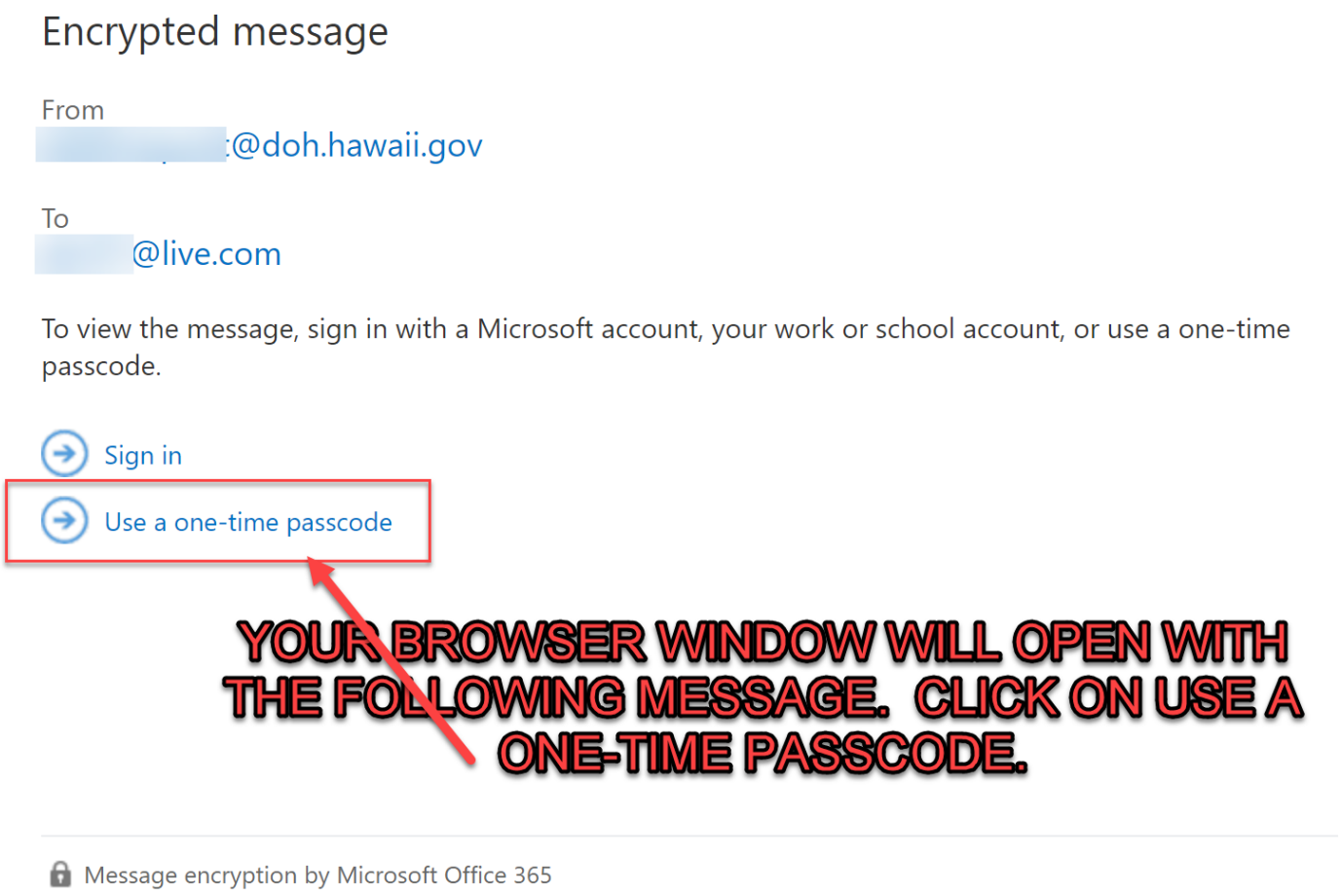
2. If the HTML file does not open when you double click, you will have to download (save) the file before you can open it. Once it downloads, you should be able to click on it to open. The message page may look different depending on the email account and browser you are using. The example below is opening Gmail in Google Chrome on a desktop computer.



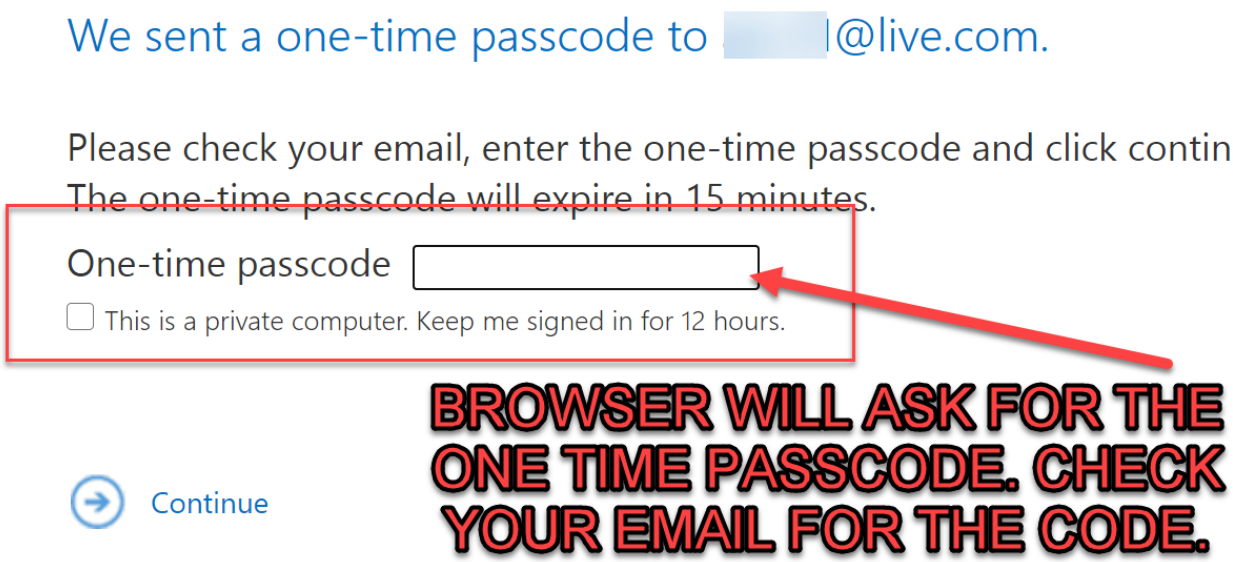



Gmail
Search mail
Compose
Inbox 270
Starred
Snoozed
Important
Sent
Drafts
Categories
Notes
Personal
More
This is a test *secure*
Inbox ×
You've received an encrypted message from @doh.hawaii.gov To view your messageSave and open the attachment (message.html), and follow the instructions
Offi...@...microsoft.com
You've received an encrypted message from @gmail.com
message.html
Reply
Reply all
Forward
No Hangouts contacts
Find someone
Once it is finished downloading, click on it and the HTML file should open.
message (1).html

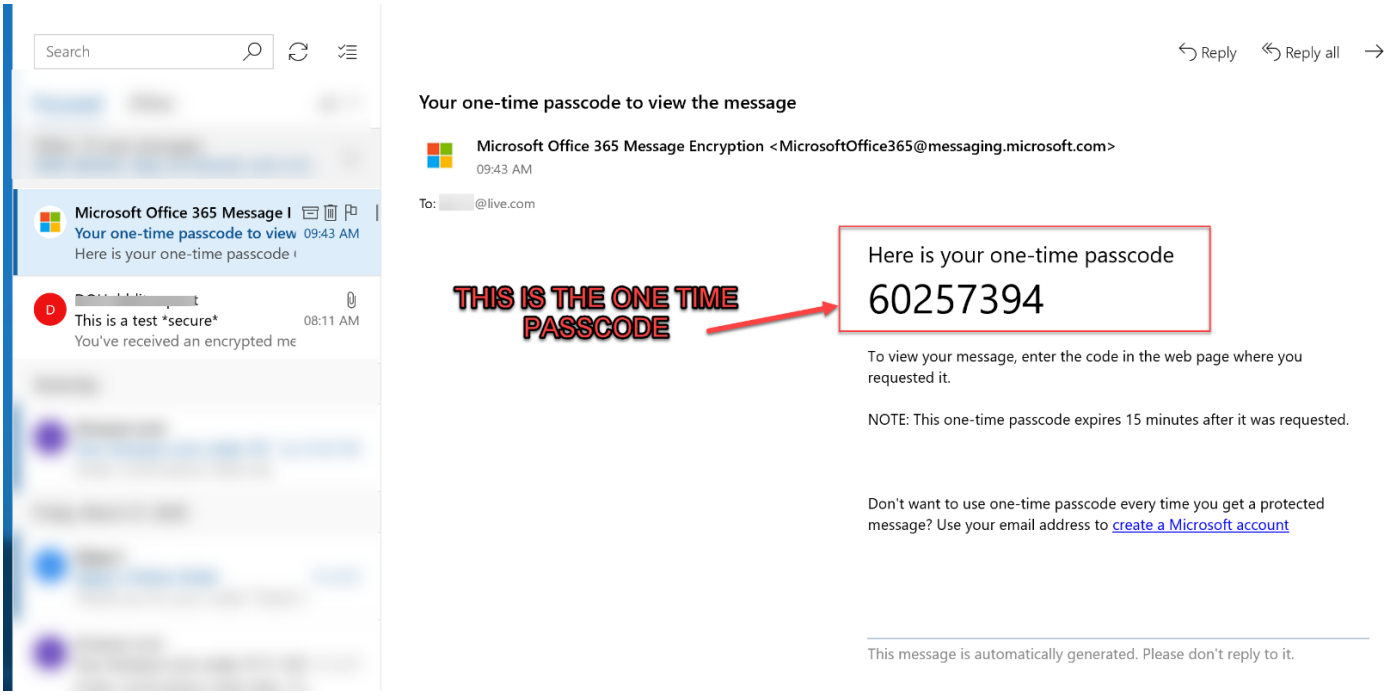
3. You will be asked how you want to open the email. Choose “Use a one-time Passcode”.



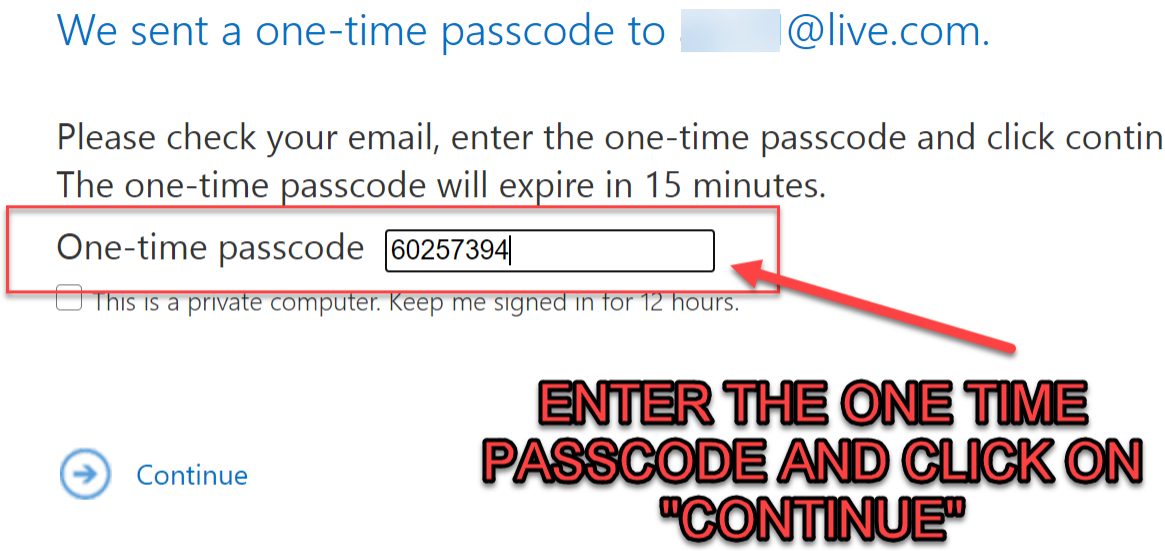
4. Browser window will now ask for a one-time passcode.



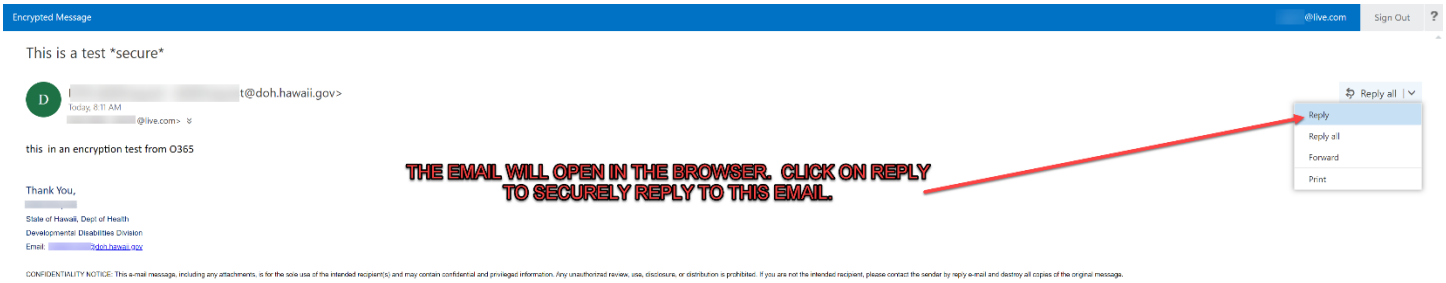
5. Check your email for the one-time passcode.



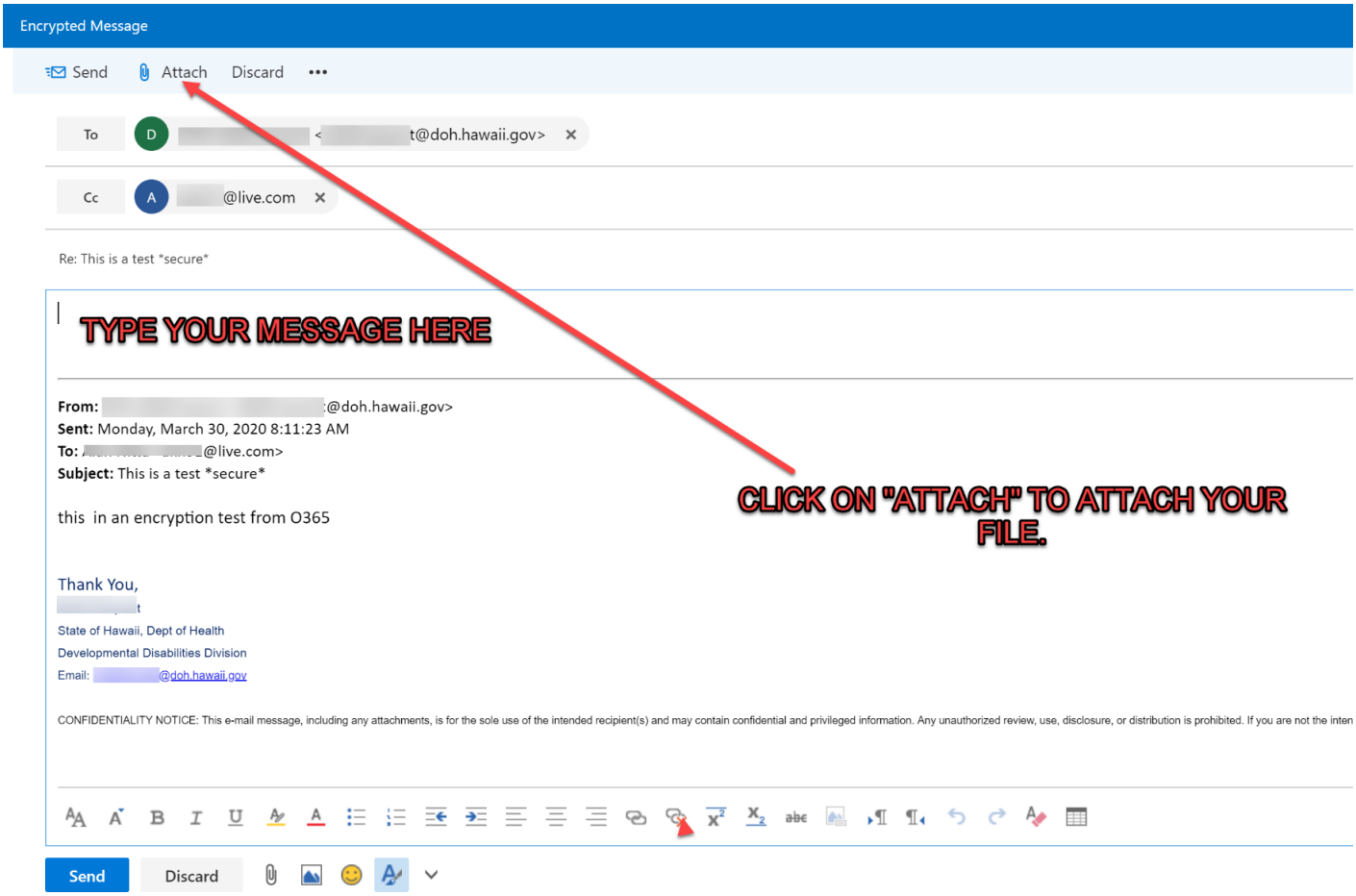
6. Enter the one-time passcode.



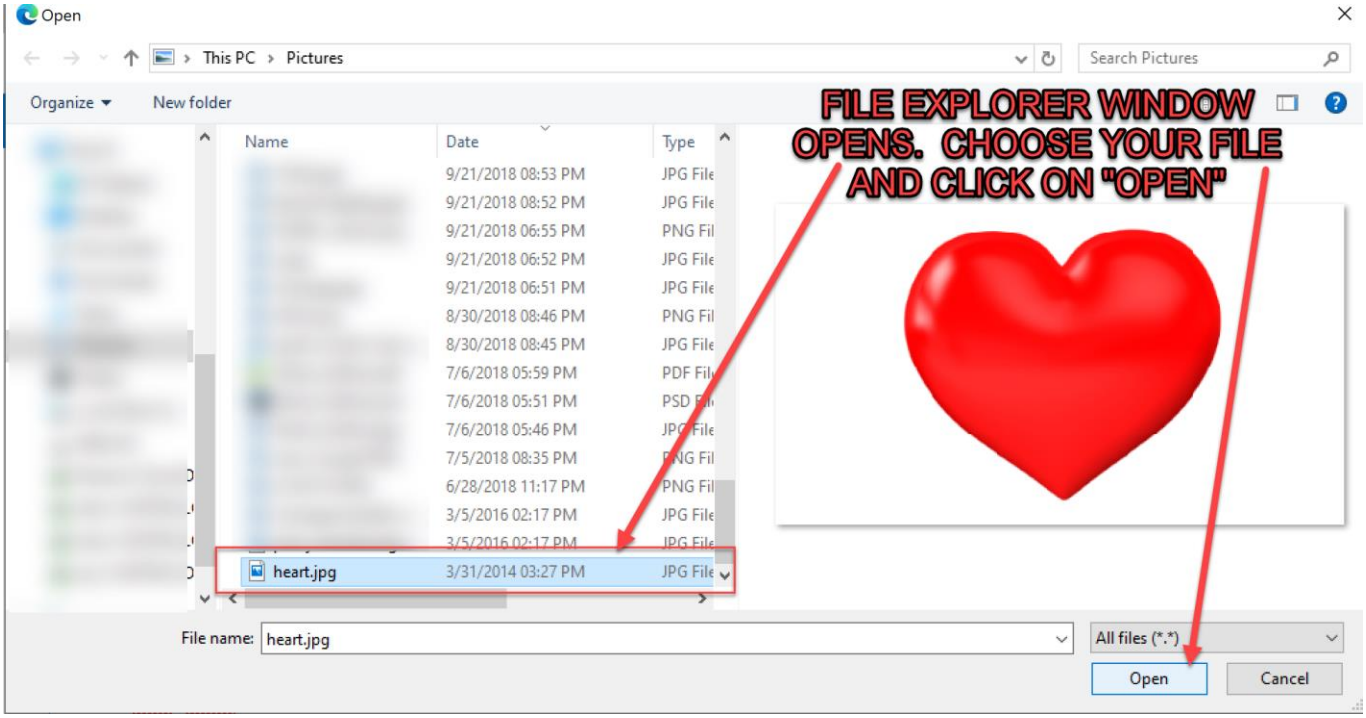
7. Your email will open in the browser window. Click on “Reply” to reply to this email.



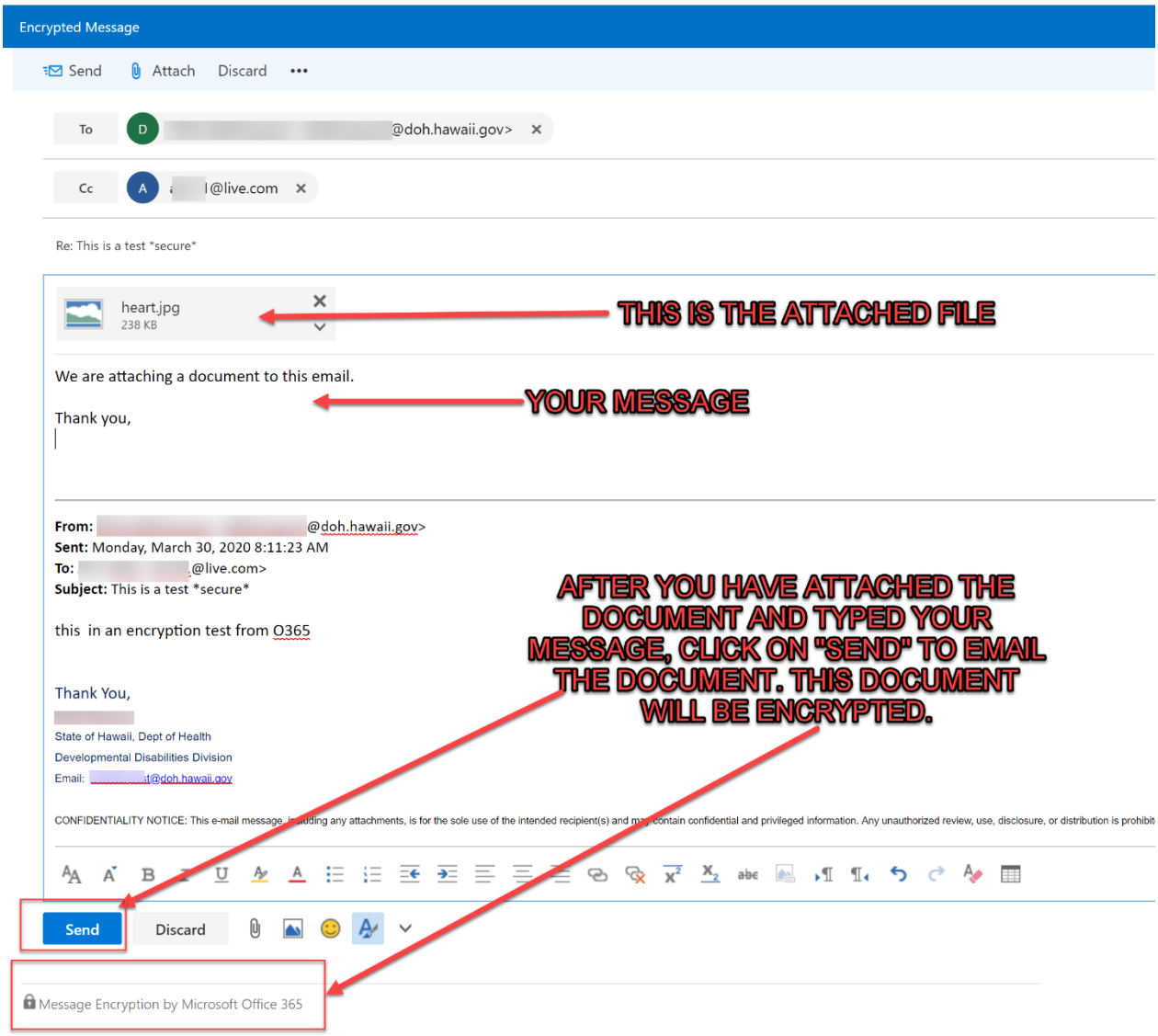
8. Type your message and attach the document.



9. Browse for the document you want to attach and click on “Open”



10. Click on “Send” to send the encrypted email.


Encrypted Message
Send
Attach
Discard
To
@doh.hawaii.gov>
Cc
@live.com
Re: This is a test *secure*
heart.jpg
238 KB
THIS IS THE ATTACHED FILE
We are attaching a document to this email.
Thank you,
YOUR MESSAGE
From: @doh.hawaii.gov>
Sent: Monday, March 30, 2020 8:11:23 AM
To: @live.com>
Subject: This is a test *secure*
this in an encryption test from O365
Thank You,
State of Hawaii, Dept of Health
Developmental Disabilities Division
Email:
CONFIDENTIALITY NOTICE: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibit
AFTER YOU HAVE ATTACHED THE DOCUMENT AND TYPED YOUR MESSAGE, CLICK ON "SEND" TO EMAIL THE DOCUMENT. THIS DOCUMENT WILL BE ENCRYPTED.
Send
Discard
Message Encryption by Microsoft Office 365

Attachment D: COVID-19 Case Management Branch (CMB) Contact Information/Directory

Section/Unit	Supervisor Name	E-Mail	Main Contact Number
Case Management East			
East Section	Jan Mori, Section Supervisor	jan.mori@doh.hawaii.gov	(808) 733-9176
CMU 1	Cindi Kim	cindi.kim@doh.hawaii.gov	(808) 733-8379
CMU 4	Caroline Hanaoka	caroline.hanaoka@doh.hawaii.gov	(808) 233-5371
CMU 7	Lyndall Kawakami	lyndall.kawakami@doh.hawaii.gov	(808) 453-6594
CMU 8	Debbie Uyeda	debora.uyeda@doh.hawaii.gov	(808) 453-5985
Hawaii Island - CMU 9 (Hilo), CMU 10 (Kona), CMU 11 (Waimea)	Cecilia Adams	cecilia.adams@doh.hawaii.gov	(808) 937-8981
Case Management West			
West Section	Earl Young, Section Supervisor	earl.young@doh.hawaii.gov	(808) 453-6105
CMU 2	Scott O'Neal	scott.oneal@doh.hawaii.gov	(808) 692-7485
CMU 3	Alan Tanji	alan.tanji@doh.hawaii.gov	(808) 692-7493
CMU 5	Kathy Yamaguchi	kathy.yamaguchi@doh.hawaii.gov	(808) 453-5925
CMU 6	Laynette AhSing	laynette.ahsing@doh.hawaii.gov	(808) 453-5935
Maui County – CMU 12 (Maui), CMU 13 (Molokai), CMU 14 (Lanai)	Jennette Cavalier	jennette.cavalier@doh.hawaii.gov	(808) 243-4625
CMU 15	Ray Ho	ray.ho@doh.hawaii.gov	(808) 241-3406
Case Management Branch Administration			
CM Branch	Sandy Kakugawa, Branch Chief	sandra.kakugawa@doh.hawaii.gov	(808) 733-9174
Consumer Directed Services	Robert Jones	robert.jones@doh.hawaii.gov	(808) 733-9191

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