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

WAIVER PROVIDER STANDARDS MANUAL

Version A

State of Hawai'i
Department of Health
Developmental Disabilities Division

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NAVIGATING THE DOCUMENT:

The Waiver Standards are organized into five main sections:

1. General Requirements and Information
2. Quality Management Overview and Requirements
3. Waiver Agency Provider General Requirements and Standards
4. Service-Specific Performance Standards
5. Appendices & Resources

The word "*participant*" is used throughout the Medicaid I/DD Waiver Provider Standards Manual (Waiver Standards) and describes an individual who is enrolled and participating in the Medicaid I/DD Waiver. Throughout the document, the waiver is referred to as the "Medicaid I/DD Waiver."

Definitions used in the Waiver Standards are found in Appendix 1.

Acronyms and abbreviations used throughout the Waiver Standards are found in Appendix 2.

The Waiver Standards will be reviewed at regular intervals and updated if needed. Updated versions will be lettered and dated in the lower left corner of the document. Changes in the Waiver Standards document will be highlighted and dated. When a new version is completed, it will be posted on the DDD website at http://health.hawaii.gov/ddd/

Summary of Changes

Changes to the Waiver Standards effective April 1, 2022, reflect the changes that have been approved by the Centers for Medicare and Medicaid Services (CMS) in the Waiver Amendment 02.

All changes in Waiver Standards Version A effective April 1, 2022, are summarized in the table below. NOTE: Waiver Standards effective July 1, 2021, ended effective March 31, 2022.

TABLE: Summary of Changes in Waiver Standards effective July 1, 2021 and Changes in Waiver Standards effective April 1, 2022

Page	Section	Topic	Summary of Change
16	Introduction	Possibilities Now!	Added language about Continuous Quality Improvement and quality management
20	Introduction	Provider Portal	Added language about the Provider Portal
21	Introduction	Electronic Visit Verification (EVV)	Added language about new EVV requirement Added geographic location as an additional data point captured through the EVV system
32	1.4.A	Level of Care Re-Evaluation	Updated process to include requirement for DOH-DDD to submit forms to DHS-MQD
32	1.5.A	ISP Development, Updates, and Revisions	Added option for participants to choose to have their ISP meeting in-person or by telehealth
36	1.5.C	Exceptions Review	Added information on the Exceptions Review process
44	1.7.D	Nursing Assessment and Delegation	Added language about nursing assessment for participants whose health and safety needs include nursing tasks, performed during waiver service hours; revised language about nurse delegation
50	1.8	Consumer Direction (CD)	Added information about the CD option and the roles and responsibilities of the CD Employer and Fiscal Management Services
55	2	Quality Management	New Section on Quality Management Overview and Requirements
67	3.1.C	Applying for Or Amending Participation As A Medicaid I/DD Waiver Provider	Revised the application and amendment process to include EVV, DHS-MQD's HOKU Provider Enrollment System and DOH-DDD's Provider Portal. Added language the Provider agreement is revalidated every five (5) years and completed online using HOKU.
70	3.2.A	HIPAA	Added new requirement for Providers to conduct annual training on HIPAA Privacy and Security for all staff

Page	Section	Topic	Summary of Change
71	3.2.D	HCBS Final Rule	Added language about overview requirements if a participant needs a modification Added language that Providers who do not demonstrate compliance will be required to complete a Corrective Action Plan (CAP) and may be subject to sanctions
72	3.2.E	Electronic Visit Verification (EVV)	Added EVV to General Requirements for Providers
72	3.2.F	Transition, Coordination, and Continuity of Care	Added Provider capacity as a type of change and transition
75	3.3	Health and Welfare of Participants	New Section; Adverse Event Reporting and Provider Safety Measures were moved to this section
75	3.3.A	Adverse Event Reporting	Updated Types of Adverse Events, Medication errors to include failure to document or incorrect documentation; changed written reporting timeframe to three days or next business day; added Table 3.3-1 and 3.3-2 with verbal and written timeline examples; changed requirement for written reports to be submitted through the Provider Portal
80	3.4.B	Training Requirements	Updated training topics list to include two new mandatory topics required annually: Civil Rights and HIPAA Privacy and Security; and revised Positive Behavior Supports and Restrictive Interventions to include Prohibited Restrictive Interventions
81	3.4.C	General Staff and Licensed/Certified Caregiver Qualifications	Revised First Aid and CPR training requirement to be completed face-to-face or on-line; revised First Aid requirement to be waived for licensed nurses; revised TB Clearance to include testing or screening in accordance with HAR 164.2; added language about Statement of Authenticity

Page	Section	Topic	Summary of Change
88	3.5.A	Individual Plan Development and Updates	Removed requirement for an initial IP; revised timeframe for distributing a copy of the IP to 7 business days of completion of the IP;
90	3.5.C	Oversight and Monitoring Responsibilities	Revised process for demonstrating use of a HIPAA-compliant platform before using a technology-based alternative format for observations/reviews of service(s); clarified observation/review requirement
94	3.6.A	Billing for Claims	Added language on billing for services subject to EVV
99	3.7	Fiscal Accountability	Revised Documentation Requirements For All Billable Claims and Fiscal Audit sections to reflect updated information and processes
105	3.7.C	Independent Audits	Updated language to reflect change in the requirement
106	3.8.A	DOH-DDD Responsibilities	Revised language about Special Monitoring Reviews and/or Investigations
110	3.8.B	Provider Responsibilities	Added language about Corrective Action Plan requirements that result from a Special Monitoring Review and/or Investigation; and updated language about HCBS final rule remediation
114	4.1	Telehealth	New section; added language about Telehealth as a modality for service delivery for Community Navigator, IES and T&C
116	4.2	ARS	Added language that T&C may be delivered concurrently (same 15-minute period) with ARS
121	4.3	ADH	Removed annual limit; added language that T&C may be delivered concurrently (same 15-minute period) with ADH
134	4.5	Chore	Added language that Chore is subject to EVV
137	4.6.1	CLS-G	Removed annual limit; added language that T&C may be delivered concurrently (same 15-minute period) with CLS-G

Page	Section	Topic	Summary of Change
143	4.6.2	CLS-Ind	Added language that T&C may be delivered concurrently (same 15-minute period) with CLS-Ind; removed requirement for the service to fade; added additional staff to participant ratios allowed when used at the participant's workplace; added language to clarify participant's choice to select a Provider to support them at their workplace; revised requirement for the assessment for ongoing supports at the workplace to be completed by the CM; added language to clarify that Non-Medical Transportation may not be used to transport the participant to/from or during service hours Added limit of 16 hours (64 units) per day Removed the language that limited the use of CLS-Ind at work
154	4.7	Community Navigator	New Service added Clarified that community integration training is required for all Community Navigators
175	4.10	IES	Changed limit for IES-Job Development to eighty (80) hours per Plan Year Added language to provide examples of reimbursable activities that are not face-to-face
183	4.11	Non-Medical Transportation	Removed time limit on use of the service for employment; added language that service may not be used to transport participants to/from services that include transportation
186	4.12	PAB	Added language that PAB is subject to EVV and T&C may be delivered concurrently (same 15-minute period) with PAB Added language that PAB is allowed in an acute hospital setting. Added language that PAB retainers may be authorized during hospitalization

Page	Section	Topic	Summary of Change
198	4.14	PDN	Added language that PDN is subject to EVV; removed requirement that the participant must receive a habilitative service
205	4.15	ResHab	Removed language that distinguished between agency and shared living models and revised to focus on the requirements, expectations and oversight of the service; added language that T&C may be delivered concurrently (same 15-minute period) with ResHab
213	4.16	Respite	Added language that Respite is subject to EVV and T&C may be delivered concurrently (same 15-minute period) with Respite Added language that Respite can be delivered in community settings Added language to clarify that Respite may include general supervision, during overnight hours when the worker is required to be present and responsive to participant needs
225	4.18	T&C	Revised language for authorization and documentation requirements Added language to clarify that Case Managers can authorize two (2) hours for the Nursing Assessment annually and additional Nursing Assessments may be authorized for significant changes in the participant's condition Added language that Providers must use the Provider Nurse Delegation Packet when completing the Nursing Assessment and the delegation plan must be updated and signed annually Separated language for T&C Dietician from T&C OT/PT/Speech-Language and clarified that T&C OT/PT/Speech Language may be authorized for assessments for AT and SMES and T&C OT/PT may be authorized for assessments for Vehicle Modifications

Page	Section	Topic	Summary of Change
244	4.19	Vehicle Modifications	Added language that assessment and training is not included in the service and the service may interface with T&C Added an exception review to Vehicle Modifications for requests that exceed the limit of $36,000; and removed sublimit of $6,000 for shipping costs Added language to allow assessments to be completed through T&C OT or T&C PT
248	4.20.1	Waiver Emergency Services - CMO	Added clarification that the service must be face-to-face with the participant for more than fifty percent (50%) of the time of the visit.

INTRODUCTION

The Hawai‘i Department of Health (DOH), Developmental Disabilities Division (DDD) operates a statewide system of services and supports for individuals with intellectual and developmental disabilities (I/DD) in Hawai‘i. DDD is the operating agency for the State of Hawai‘i’s Medicaid 1915(c) Home and Community Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (Medicaid I/DD Waiver). The overarching goal of DDD is to support people in maximizing opportunities to have the lives they choose in their communities. The purpose of the Medicaid I/DD Waiver Provider Standards Manual (Waiver Standards) is to provide clear and consistent guidance in alignment with the Medicaid I/DD Waiver about the DDD service system, the intent of services, and the way services are to be provided.

The Waiver Standards apply to all services provided through the Medicaid I/DD Waiver. This version of the Waiver Standards is effective April 1, 2022 replaces all previous versions.

Your feedback is important. If you have comments, questions or suggestions about the Waiver Standards, please email doh.dddcrb@doh.hawaii.gov.

DOH-DDD Mission, Vision and Guiding Principles

Mission
Foster partnerships and provide quality person-centered and family-focused services and supports that promote self-determination.

Vision
Individuals with intellectual and developmental disabilities will have healthy, safe, meaningful and self-determined lives.

Guiding Principles
Individuals:

- are treated with respect and dignity,
- make their own choices,
- participate fully in the community,
- have opportunities to realize their goals including economic self-sufficiency,
- achieve positive outcomes through individualized services and natural supports, and
- are empowered to live self-determined lives.

Possibilities Now!

People with disabilities have a right to live and participate fully in the community throughout their lives. DOH-DDD is committed to ensuring each participant of the Medicaid I/DD Waiver has the inclusive, quality life that they choose. DOH-DDD's overall commitment toward this goal is called Possibilities Now!

Supporting possibilities for each person to live the life they want across their lifespan can include relationship-based supports, technology, community resources, and eligibility-specific supports such as services through the Medicaid I/DD Waiver. Building on the skills, strengths, and life experiences of the individual and family is critical when it comes to planning and supporting a person's vision of a good life.

There are three highly-connected foundations for Possibilities Now! They are:

1. Person-Centered Planning, Supports and Services
2. Commitment to Continuous Quality Improvement
3. Community Integration

1. Person-Centered Planning, Supports and Services
   DOH-DDD is committed to person- and family-centered practices across all aspects of planning and service delivery. Person- and family-centered practices include thinking and acting in ways that see people using services as equal partners in planning, developing, and monitoring care to make sure services and supports meet their needs. This means

putting people and their families at the center of decisions and seeing them as experts working alongside professionals to get the best outcomes.

People have different needs, interests, and goals during their lives. Person-centered supports focus on a participant's right to choose, direction, and control. It is the person's right to identify and pursue what is important to them in addition to what is important for them. Person-centered supports put the person at the center of their own decision-making. With person-centered supports, a participant identifies and pursues what is most important in their life.

- *Charting the LifeCourse*
  Person-centered support starts with assessment through listening to the person and honoring their vision for a good life. The participant's vision for a good life may be mapped on a Charting the LifeCourse Trajectory to identify both what the individual wants and doesn't want in their life. In person-centered planning, the person directs the development of the plan, which describes the life they want to live in the community. Services and supports are coordinated across providers and systems to carry out the plan and ensure fidelity to the person's expressed goals, needs, preferences, and values.

  Support to families of participants is a key aspect of achieving each person's vision of a good life in the community. The overall goal of supporting families, with all of their complexities, strengths and unique abilities, is so they can best support, nurture, love and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion of their family members in all facets of community life (*Administration on Intellectual and Developmental Disabilities (AIDD) National Agenda on Family Support Conference*, 2011).

  The goal is for person-centered assessments and individual support plans that facilitate positive outcomes, including improved health and functioning, higher quality of life, and achievement of the person's goals.

- *Self-Determination*
  Self-determination is a key component of person-centered supports. Self-determination means that people have authority over their own lives. It means that participants have control of the resources needed for their support, as well as responsibility for their decisions and actions. Participants and families are entitled to the freedom, authority, and support to control, direct, and manage their own services, supports, and funding. Participants and families can choose their own services and supports based on assessment of support needs and service guidelines.

Participants and families also have choice in deciding how and by whom supports are provided.

- *Individual Supports Budgets*
  Individual Supports Budgets were phased in during the previous waiver starting in 2019. Participants are informed of their budgets and make decisions about the services that best meet their needs within that budget. As a result, participants gain authority over their services, and subsequently can be more in charge of their own lives. Individual supports budgets enhance the person-centered process by allowing participants to take an active role in every part of the planning process.

  The person-centered Individualized Service Plan (ISP) must be developed through a person-centered planning process as described in Section 1.5. The ISP is the written agreement between the waiver participant, circle of supports, providers and DOH-DDD.

2. Commitment to Continuous Quality Improvement

   Overview of Quality Management in HCBS

> ***Quality comes from a commitment to improvement and outcomes and maintaining a systematic and continuous improvement process.***

Nationally, HCBS programs are moving increasingly beyond defining quality by only compliance to regulations, to providing services built on a continuous improvement foundation. Continuous Quality Improvement (CQI) involves maintaining a quality management structure that is accountable for implementing and tracking improvements, using CQI tools and available data to identify opportunities for improvement, and creating organizational cultures that value quality. This approach can increase programs' capabilities for balancing quality of life, participant outcomes and community integration with compliance-oriented assurances. This requires leaders to purposefully build cultures of quality, and to work on meaningful changes throughout the agency that can be sustained.

Quality management in HCBS is defined to encompasses three functions:

- *Discovery:*
  Collecting data and direct participant experiences to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.

- *Remediation:*
  Taking action to remedy specific problems or concerns that arise.

- *Continuous Improvement:*
  Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

3. Community Integration

CMS Home and Community Based Services (HCBS) Final Rule (79 FR 2947) on Community Integration (HCBS final rule)In 2016, the National Quality Forum (NQF) defined home and community-based services (HCBS) as "an array of services and supports delivered in the home or other integrated community setting that promote the independence, health and well-being, self-determination, and community inclusion of a person of any age who has significant, long-term physical, cognitive, sensory, and/or behavioral health needs."

CMS issued a final rule (79 FR 2947) on community integration that addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. The HCBS final rule on community integration:

- supports enhanced quality in HCBS programs,
- adds protections for individuals receiving services,
- defines person-centered planning requirements,
- defines and describes the requirements for HCBS settings appropriate for the provision of HCBS under section 1915(c) waivers, and
- creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics.

The HCBS final rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid-funded HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. The

HCBS final rule also helps to ensure participants are informed and supported to exercise their freedom of choice in selecting:

- between institutional or home and community-based waiver services,
- among services and supports from the array based on the Individualized Service Plan (ISP), and
- their providers.

Since Hawai‘i’s Medicaid I/DD Waiver operates under the authority of section 1915(c) of the Social Security Act, all waiver services must align with the HCBS final rule. CMS has granted states an extension until March 2023 to reach full compliance. Each state specifies its timelines to reach the milestones toward full compliance in the CMS-approved transition plan. Hawai‘i’s state transition plan is called My Choice My Way.

For Medicaid I/DD Waiver Providers (Providers), the transition period applies only to Providers that were in operation and providing the HCBS service(s) prior to July 1, 2016. Any Providers that are not in full compliance as determined by the My Choice My Way validation, must develop and implement remediation plans to achieve full compliance with the HCBS final rule requirements and maintain compliance on an ongoing basis.

All prospective Provider applicants and existing Providers seeking to add a new service or a new setting after July 1, 2016, must be in full compliance with the HCBS final rule before DDD can recommend an applicant to MQD or approve the request to add a new service or setting. There are no exceptions. CMS has issued guidance that the transition period is not available for a new Provider applicant or an existing Provider seeking to add a new service or a new setting.

For more details, please refer to the CMS website at:

https://www.medicaid.gov/medicaid/hcbs/guidance/index.html.

Provider Portal through INSPIRE

DOH-DDD is committed to making system improvements and supporting quality and effective coordination of care. DOH-DDD will be implementing a Provider Portal through its case management platform, INSPIRE. Providers will use the Provider Portal to perform the following types of tasks as they are phased in:

- Update Provider agency and staff information
- Receive and respond to referrals for services from case managers
- View and print completed Individualized Service Plans (ISPs) and LifeCourse tools
- Complete and submit Adverse Event Report (AER) forms to DOH-DDD
- Upload and receive documents to and from DOH-DDD

- Complete and submit Individual Plans (IPs) and Quarterly Reports to case managers

Individual Rights and Protections

Waiver services must be delivered to participants in accordance with the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Public Law 106–402) that ensures participants "*live free of abuse, neglect, financial and sexual exploitation, and violations of their legal and human rights*." Providers must afford the rights and protections specified in Section 1.6 in any setting where waiver services are delivered.

Electronic Visit Verification (EVV)

In December 2016, Congress passed the 21st Century Cures Act (Cures Act) which requires states to use EVV for personal care services (PCS) by January 1, 2020, and home health services that requite an in-home visit by a provider by January 1, 2023. PCS in the Medicaid I/DD Waiver include:

- Personal Assistance/Habilitation (PAB)
- Respite
- Chore
- Private Duty Nursing (PDN)

The use of EVV aligns with the State's goal continue to improve service delivery and ensure program integrity. The DHS-MQD selects a state-wide EVV vendor for Hawai'i and assures that the EVV system follows federal and state rules and is designed to protect participants' privacy. Providers of PCS must use an EVV system to capture the following information:

1. Participant's name
2. Geographic location
3. Type of service (PAB, Respite, Chore or PDN)
4. Date of service
5. Start and End time(s) of each visit
6. Verification of each visit by the participant or their designee

SECTION 1:
GENERAL REQUIREMENTS & INFORMATION - WAIVER OVERVIEW

1.1 – WAIVER OVERVIEW

A. Medicaid I/DD Waiver Purpose and Objectives

Medicaid 1915(c) Home and Community-Based Services (HCBS) waivers, authorized under §1915(c) of the Social Security Act, provide services in homes and communities where people live rather than in institutional settings. The federal law permits a state to develop an array of home and community-based services that help Medicaid beneficiaries live in the community and avoid institutionalization. States have broad discretion to design their waiver programs to address the needs of the waiver's target population.

All HCBS waiver programs must:

- Demonstrate that providing waiver services won't cost more than providing these services in an institution
- Ensure the protection of people's health and welfare
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services follow an individualized and person-centered plan of care

Waiver services complement and supplement services available to participants through the Medicaid State Plan and other federal, state, and local public programs, as well as the supports that families and communities provide.

Hawai'i's Medicaid I/DD Waiver enables individuals with intellectual and developmental disabilities (I/DD) who meet an institutional level of care the choice to live in their homes and communities with appropriate quality supports designed to promote their health, community integration, safety and independence.

The overarching goals of the Medicaid I/DD Waiver are to:

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

2. Evaluate and continuously improve the quality of services to participants, including measuring the satisfaction of the benefits and services the participants receive, to improve them.

As mentioned above, the Medicaid I/DD Waiver uses federal Medicaid funds and State matching funds for HCBS as an alternative to institutional services, provided that the overall cost of supporting individuals in their homes and communities is no more than the institutional cost for supporting that same group of individuals. This is called "cost neutrality."

The Medicaid I/DD Waiver also requires that the State meet assurances required in the law. Hawai‘i must report to CMS annually its performance measures to demonstrate compliance with the federally-mandated assurances.

B. Eligibility for Waiver Services

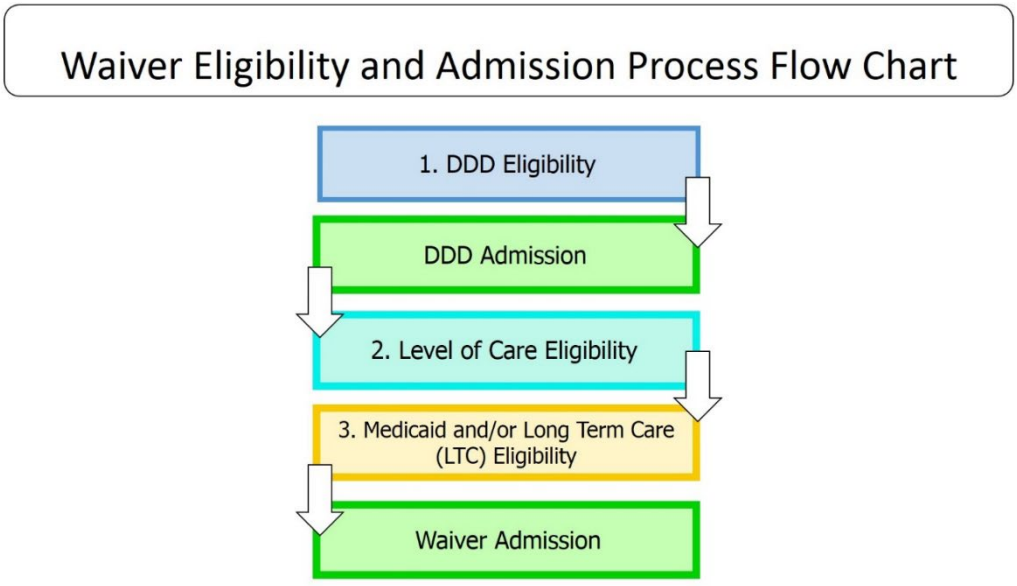
Individuals interested in applying for Hawai‘i’s Medicaid I/DD Waiver must first be determined eligible for DOH-DDD services (STEP 1). After the determination of eligibility is made, the individual may apply for admission to the Medicaid I/DD waiver by completing STEP 2 and STEP 3.

STEP 1: Meets DOH-DDD eligibility requirements. Once eligible, the individual can receive DDD services based on their support needs.

STEP 2: Meets DHS-MQD Level of Care eligibility criteria; and

STEP 3: Meets DHS-MQD Medicaid and Long-Term Care (LTC) eligibility criteria. If determined to meet STEP 2 and STEP 3, the individual may choose to be admitted to the waiver.

The application process is described in Section 1.3: Application for Waiver Services.



C. Definition of Developmental Disability and Intellectual Disability

Hawai‘i has defined Developmental Disability and Intellectual Disability in Chapter 333F, Hawai‘i Revised Statutes (HRS).

1. “Developmental Disabilities" means a severe, chronic disability of a person which:
    a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
    b. Is manifested before the person attains age twenty-two;
    c. Is likely to continue indefinitely;
    d. Results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
    e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

    An individual from birth to age nine who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above, if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. "Intellectual Disability" means significantly sub average general intellectual functioning resulting in or associated with concurrent moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period.

D. Coordination with Medicaid State Plan Services through QUEST Integration

DDD will coordinate services with QUEST Integration health plans for participants in need of State Plan Services and any needed transition supports.

E. Access and Availability

Waiver participants must have access to all Medicaid I/DD Waiver services, regardless of where the participant lives. Providers must ensure the following:

1. The Providers must have capacity to serve the geographic area for every service proposed in its Waiver Provider application;
2. If the Provider no longer has the capacity to serve an area and/or island or provide a particular waiver service, even though it may still be providing services elsewhere, the Provider must notify DOH-DDD in writing at least 30 calendar days in advance of the requested change. The written notification must include the reason for the request and

information detailing coordination efforts with the DOH-DDD Case Manager (CM) to transition participants who are currently receiving services to a new Provider.

- DOH-DDD may request additional time beyond the 30 calendar days to allow for smooth transition for participants to locate other Providers.

1.2 - ROLES AND RESPONSIBILITIES

A. Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services, is the federal agency that administers the Medicare and Medicaid programs that provide health care to the aged and indigent populations. The Social Security Act §1915(c) enables states to provide HCBS through a waiver to a target group, such as individuals with intellectual and developmental disabilities.

CMS reviews all waiver requests, applications, renewals, amendments, and financial reports. CMS performs management reviews of all HCBS waivers to ascertain their effectiveness, safety, and cost-effectiveness. CMS requires states to assure that federal requirements for Hawai'i's Medicaid I/DD Waiver service are met and verifies that the State's assurances in its waiver program are upheld in the day-to-day operations.

B. State Medicaid Agency

The Department of Human Services (DHS) is the single State agency that is responsible for the Medicaid program for the State of Hawai'i. The Med-QUEST Division (MQD) within the DHS is responsible for overall administration of the Hawai'i Medicaid program, including the Section 1115 demonstration program known as QUEST Integration (QI) and the Medicaid I/DD Waiver.

Additional information about the roles and responsibilities for DHS-MQD is located in Appendix 11A.

C. State Operating Agency

The Department of Health (DOH) is the State agency that is responsible for providing services to individuals with developmental disabilities and/or intellectual disabilities. The Developmental Disabilities Division (DDD) within DOH has statutory responsibilities to "develop, lead, administer, coordinate, monitor, evaluate, and set direction for a comprehensive system of supports and services for persons with developmental disabilities and/or intellectual disabilities within the limits of state or federal resources allocated or available …" (HRS §333F-2)

DOH-DDD is delegated by DHS-MQD to operate the Medicaid I/DD Waiver through a Memorandum of Agreement.

Additional information about the roles and responsibilities for DOH-DDD is located in Appendix 11B.

D. Medicaid I/DD Waiver Providers

A Medicaid I/DD Waiver Provider (Provider) is an individual, company or organization that DOH-DDD has recommended approval to enter into a Medicaid Provider Agreement with DHS-MQD. Approved Providers can submit authorized claims to provide direct services to Medicaid I/DD Waiver participants in compliance with all waiver requirements, federal and state laws, and Waiver Standards. Providers may be for-profit or non-profit entities. Provider requirements and responsibilities are specified in Section 3.

E. Participant, Family and Guardian Responsibilities

The general responsibilities of participants and individuals, including guardians and family, interested in or already receiving services from the Medicaid I/DD Waiver include:

1. Participate in the application process for Medicaid I/DD Waiver;
2. Provide information needed to determine Level of Care Re-evaluations (LOC) within 365 days of the last re-evaluation. Participants will submit verification of a physical examination or evaluation once a year;
3. Participate in redeterminations for DOH-DDD eligibility. The participant must continue to meet the criteria for services per HRS §333-F;
4. Maintain Medicaid eligibility at all times. Complete and return paperwork for initial and ongoing Medicaid eligibility determinations. Inform the Medicaid eligibility worker of all pertinent changes;
5. Be financially responsible for payment of Medicaid waiver services received when Medicaid eligibility is lost. The State will not pay for Medicaid waiver services when the participant is not Medicaid eligible;
6. Work with their Case Manager (CM) to complete any assessments needed including the Inventory for Client and Agency Planning (ICAP) and Supports Intensity Scale (SIS), as applicable, prior to the ISP meeting;
7. Participate in their ISP meeting within 365 days of the last ISP meeting (i.e. three months but no later than two weeks prior to the annual plan year start date);
8. Approve the ISP within 14 days of receiving a copy of the ISP;
9. Inform the CM if there is reason to believe that services are not being provided according to the ISP;
10. Meet with the CM at least once every quarter to review services according to the ISP;
11. Inform the CM of changes to contact information and living arrangement, such as address and phone number changes;
12. Inform the CM of any hospitalization and scheduled vacation(s) where they will not be receiving services as soon as possible;
13. Inform the CM of satisfaction or lack of with any services from DDD or call the Consumer Complaints Resolution Unit;
14. Provide true and complete information about coverage, services, and any required financial information;
15. Use resources wisely and responsibly; and

16. Work with the Provider to schedule and complete required face-to-face observations/reviews of service delivery.

1.3 - APPLICATION AND START OF WAIVER SERVICES

The DOH-DDD CM must inform the participant of all options regarding services and available providers through the Medicaid I/DD Waiver. The CM will assist individuals who are enrolled with DOH-DDD and have requested to participate in the Medicaid I/DD Waiver. Enrolling with DOH-DDD does not automatically enroll the individual in the Medicaid I/DD Waiver because there are additional eligibility requirements, and the individual must be approved by DHS-MQD to participate in the Waiver. As described in Section 1.1.B, an individual must meet all three of the steps before being admitted to the Medicaid I/DD Waiver.

If DHS-MQD determines the applicant ineligible for the Medicaid I/DD Waiver, DHS-MQD will issue a Notice of Action (NOA) to the applicant, stating the reason for ineligibility and the applicant's appeal rights.

F. Medicaid "Cost Share" for Adults

An individual who does not fully meet the financial requirements for Medicaid eligibility due to the amount of his/her monthly income may be required to pay a portion of the medical expenses and/or waiver services each month, in order to be eligible for Medicaid. The portion of medical expenses and/or waiver services the individual must pay each month is referred to as their "cost share." The individual becomes Medicaid eligible once he/she has met the cost share requirement.

1. If a participant has a monthly cost share amount, the cost share must be paid by the participant directly to the Provider(s) servicing the participant.
2. If there is more than one Provider, the "designated" Provider shall be the Provider with the largest cost and is responsible for the monthly cost share collection from the participant.
3. The "designated" Provider must adjust the monthly billing invoice for waiver services by the participant's cost share amount.
4. The "designated" Provider(s) is responsible for the monthly cost share collection from the participant.

G. Financial Eligibility Requirements for Children

1. A child may be Medicaid eligible if the family is financially eligible for Medicaid.
2. If the child's family is not Medicaid eligible, but the child has been determined to meet the LOC criteria, a process called "deeming" is used by DHS-MQD. When the estimated

medical expenditures exceed the family's excess income and the parents agree to pay the amount of the excess income, the child is deemed eligible for the first month of admission.
3. The parents will be responsible to pay for the excess income for the first month only which will be treated as a cost share. From the second month of admission, the child will be separated from the parents and there will be no cost share.

H. Waiver Admission

1. At a minimum, one (1) service under the Medicaid I/DD Waiver Services must be provided on the day of admission.
2. In the event of unforeseen circumstances precluding the provision of waiver service delivery on the date of admission, the CM may suspend the participant until service can be provided.
3. The participant and/or parent, or the legal guardian when indicated, are required to notify the CM when the participant does not or will not receive any waiver service(s) at start of services or at any time thereafter.

I. Hawai‘i Medicaid Identification Card

1. A Hawai‘i Medicaid identification card (ID card) will be issued by a Medicaid health plan to each participant when initial Medicaid eligibility has been determined by DHS-MQD. The ID card will only list the participant's name, Medicaid number and date of birth. The ID card will not list the participant's eligibility dates. As a result, the ID cards will not serve as evidence of current eligibility as participants will keep their ID card throughout any changes in eligibility dates. Medicaid I/DD Waiver Providers must verify each participant's eligibility.
2. Participants who have lost their ID card should be directed to contact the Medicaid health plan. Contact information is contained in the Assistance Directory in Appendix 3.

J. Verification of Medicaid Eligibility

1. The Medicaid program will only reimburse Providers for services rendered to participants with current Medicaid eligibility. If a Provider is unable to verify a participant's eligibility at the time of service, the Provider renders the service at his/her own risk. The prior authorization does not guarantee payment of a claim or verify participant eligibility at the time a service is rendered.
2. Providers must verify participant eligibility on a routine basis as there are times when Medicaid eligibility may lapse due to an incomplete or untimely re-application to Medicaid. Participants are not eligible to receive Medicaid I/DD Waiver services if Medicaid eligibility has lapsed.
3. To assist Providers in verifying participant eligibility, DHS-MQD has developed several options for a Provider to verify eligibility: Automated Voice Response System (AVRS) and

DHS Medicaid Online (DMO). (See Appendix 3, Assistance Directory for contact information.)

1.4 - RE-EVALUATION OF ELIGIBILITY FOR CONTINUED WAIVER SERVICES

In order to continue to receive Medicaid I/DD Waiver services, a participant must continue to need services through the waiver (determined by a Qualified Intellectual Disabilities Professional [QIDP]) and be eligible for Medicaid and LTC services (determined by the DHS Eligibility office). The following are the three (3) components that a participant must meet:

A. Level of Care Re-Evaluation

Participants who receive Medicaid I/DD Waiver services must be re-evaluated annually or more frequently if needed to determine whether they continue to meet the Intermediate Care Facility for Individuals with Intellectual Disabilities Level of Care (ICF-IID LOC). A physician's evaluation (or physical exam) is required and must be submitted to the Case Manager prior to the re-evaluation date. DOH-DDD must submit the DHS 1148 form with a copy of the level of care re-evaluation and physician's evaluation to DHS eligibility worker for LTC annual renewal determination.

B. Medicaid Annual Renewal

An annual renewal form is mailed to each participant in the Medicaid I/DD Waiver from DHS. The participant's information is listed on the upper portion of the renewal form. If there is no change, no action is required. This is referred to as a "passive renewal." If there are any changes, the participant will need to complete the form with updated information written on the bottom half of the form and return to the DHS eligibility worker by the due date stated.

C. Long Term Care (LTC) Annual Renewal

Around the same time the annual renewal form is mailed from DHS, the annual renewal for LTC is mailed out. If the responsible party receives the LTC forms, that person must complete the forms and return to the DHS eligibility worker by the due date stated.

1.5 - INDIVIDUALIZED SERVICE PLAN (ISP)

A. ISP Development, Updates and Revisions

All participants who receive Medicaid waiver services from the DOH-DDD must have a written ISP that is developed by the participant, with the input of family, friends, and other persons identified by the participant as their circle of support and for being important to their planning process. DOH-DDD utilizes the LifeCourse framework and tools to support participants to

develop a vision for a good life. The plan must be a written description of what is important to/for the participant, how any issue of health and safety must be addressed and integrated to support the participant in his or her desired life (see Appendix 12 for ISP form). The ISP is developed per the HRS §333F and Medicaid I/DD Waiver requirements.

1. The person-centered planning process follows the requirements of the HCBS final rule for community integration. The person-centered planning process:
   a. is driven by the participant and includes people chosen by the participant;
   b. provides necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
   c. is timely and occurs at times/locations convenient to the participant;
   d. offers informed choice regarding services and supports the participant receives and from whom;
   e. reflects cultural considerations and uses plain language;
   f. includes strategies for solving conflicts or disagreements within the process, including clear conflict-of-interest guidelines for all planning participants;
   g. reflects what is important to the participant to ensure delivery of services in a manner reflecting personal preferences, strengths and ensuring health and welfare;
   h. identifies strengths, preferences, needs, and desired outcomes of the participant;
   i. includes goals and preferences which are related to relationships, community participation, employment, and health;
   j. includes risk factors and plans to minimize them;
   k. includes a method for the participant to request updates to the plan as needed; and
   l. is signed by all individuals and providers responsible for its implementation. A copy of the plan must be provided to the participant and his/her representative.
2. The ISP is used by the CM to document the information above and includes an "Action Plan" which describes the services and supports, both paid and unpaid, to meet the goals, objectives and outcomes identified by the participant.
3. A copy of the ISP is sent from the CM to the Provider(s) within thirty (30) calendar days from the completion date of the ISP meeting with the following documents, if applicable:
   a. Individualized Educational Plan (IEP),
   b. Assessments and recommendations of health professionals (e.g., physical, occupational and speech therapists), and
   c. Positive Behavior Support Plan.
4. The ISP is updated annually and may be amended at any time upon request of the participant or when situations and/or circumstances present itself that requires adjustments to the written plan.
5. The ISP meeting may be held either in-person or by telehealth, as chosen by the participant and/or guardian, based on the participant's individual circumstances and preferences.

B. Individual Supports Budgets

Participants age 18 and older will receive a prospective Individual Supports Budget that reflects their needs and empowers them to make decisions about how to use their budget to access the supports that best meet their unique circumstances.

A participant's Individual Supports Budget is determined by their assessed needs and type of living arrangement. There are three types of living arrangements:

1. living in a licensed or certified setting
2. living in a family home
3. living in own home

Participants' support 'levels' are based on the Supports Intensity Scale®(SIS) for Adults and Hawai'i's supplemental questions. Brief descriptions of the seven levels are:

- Level 1: Low support needs
- Level 2: Low to moderate support needs
- Level 3: Moderate support needs plus some behavior challenges
- Level 4: Moderate to high support needs
- Level 5: Maximum support needs
- Level 6: Significant support needs due to medical challenges
- Level 7: Significant support needs due to behavioral challenges

The following base services are subject to the Individual Supports Budget:

- Adult Day Health
- Community Learning Service – Group
- Community Learning Service - Individual
- Personal Assistance/Habilitation (not available for participants in licensed or certified settings)
- Chore (not available for participants in licensed or certified settings)
- Respite (only available for participants living in a family home)

All other services may be authorized in addition to the amount established by a participant's Individual Supports Budget subject to determination of service necessity, applicable service limits, and authorization requirements.

TABLE 1.5.B-1: Individual Supports Budget Ranges

This is a table with the budget ranges based on SIS Level and type of living arrangement.

		Licensed/Certified Settings *(includes ADH, CLS-Ind, and CLS-G)*		**Living in Family Home** *(includes ADH, CLS-Ind, CLS-G, PAB, Chore, and Respite)*		**Living Independently** *(includes ADH, CLS-Ind, CLS-G, PAB, and Chore)*	
SIS Level	**Budget**	**All Other Islands**	**Big Island**	**All Other Islands**	**Big Island**	**All Other Islands**	**Big Island**
1	Low	$15,938	$18,555	$30,041	$34,465	$34,754	$40,887
	High	$21,250	$24,740	$40,054	$45,953	$46,338	$54,516
2	Low	$16,938	$19,698	$40,941	$47,075	$43,587	$51,102
	High	$22,584	$26,264	$54,588	$62,766	$58,116	$68,136
3	Low	$21,326	$24,588	$49,698	$56,951	$50,885	$59,508
	High	$28,434	$32,784	$66,264	$75,934	$67,846	$79,344
4	Low	$21,326	$24,588	$55,293	$63,431	**Requires exceptions review.** (Individuals living independently who have exceptional support needs are authorized on a case-by-case basis)	
	High	$28,434	$32,784	$73,724	$84,574		
5	Low	$24,477	$27,971	$74,384	$85,255		
	High	$32,636	$37,294	$99,178	$113,673		
6	Low	$25,260	$28,652	$86,070	$97,742		
	High	$33,680	$38,202	$114,760	$130,322		
7	Low	$26,055	$29,736	$86,811	$99,130		
	High	$34,740	$39,648	$115,748	$132,174		

It is recognized that while participants who are grouped in a certain level have similar support needs, each person is unique. Therefore, some participants may require supports above and beyond those permitted by their Individual Supports Budget. Requests for adjustments or exceptions to the limits must be reviewed by DOH-DDD. Adjustments or exceptions may be made for the following reasons:

- health and safety,
- to permit additional time to make support adjustments (such as the development of natural/community supports) for those who are current waiver participants, or
- to provide increased services to ensure successful transition into less restricted settings, which over time will require a less intensive level of support.

C. Exceptions Review

Participants who receive Medicaid I/DD Waiver services may request an exceptions review with the DOH-DDD to review their need for services in addition to:

1) their Individual Supports Budget,
2) service guidelines,
3) sub-limits and certain add-on services specified in the I/DD Waiver, and
4) enhanced staff ratios specified in the Waiver Standards.

Exceptions will be determined on a review of relevant information. Participants may review the information submitted on their behalf, and may submit comments, documents or other information. If services are approved, the number of units/hours/amount and duration (for how long) the additional services are authorized will be specified. If services are denied, the reason for the action and the participant's right to appeal will be clearly communicated to the participant through the Notice of Action (NOA).

D. Service Authorizations

All approved Medicaid waiver services written in the Action Plan will be authorized by the CM through INSPIRE. The Provider will be given a prior authorization notice from the designated fiscal agent (Conduent) before the delivery of services. The absence of a prior authorization will result in a denied claim for payment. The Provider must follow-up with the CM if a prior authorization has not been received for a service identified in the Action Plan.

Requests for services that exceed the authorization level that the CM can approve must be reviewed by DOH-DDD on a case-by-case basis.

E. ISP Implementation and Monitoring

At a minimum, the CM must monitor the implementation of the ISP by performing quarterly face-to-face visits with the participant. Telehealth may be used when a face-to-face visit according to policy cannot be conducted due to issues with health and safety. The CM must also conduct periodic contacts with caregivers, parents, guardians, providers, teachers, and employers etc. to assess/reassess the participant's status.

1.6 - PARTICIPANT RIGHTS AND PROTECTIONS

Participants are afforded rights and protections, including those specified in Hawai‘i Revised Statutes, §333F-8.

1. Receive appropriate services in accordance with the person's Individualized Service Plan (ISP);
2. Live in an appropriate residence;
3. Interact with persons without disabilities;
4. Live with, or in close proximity to, persons without disabilities, which closely approximates conditions available to persons without disabilities of the same age;
5. Are given reasonable access to review medical, service, and treatment records and be informed of all diagnoses;
6. Develop an ISP, with the input of family and friends, that identifies the supports needed to accomplish the plan;
7. Direct the use of resources, both paid and unpaid, that will help the individual to live a life in the community rich in community association and contribution;
8. Contribute to their communities and offer a valued role through employment, community activities, and volunteering, and be accountable for spending public dollars in ways that are life enhancing;
9. Are ensured privacy and confidentiality. The information will be kept private according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
10. Choose their services, supports, and providers. This includes the choice to receive home and community-based services as an alternative to institutional placement;
11. Complain about their services or to ask for changes without fear that they will lose services because a complaint is made;
12. Be treated with respect and dignity;
13. Be free from abuse and neglect;
14. Be informed of all services that DOH-DDD provides;
15. Be able to discuss options for services with their CM and Providers;
16. Be informed of agency policies on individual conduct;
17. Be able to ask for a different agency or CM;

18. Receive a written notice at least 10 business days prior to the effective date from the DOH-DDD when services are being reduced, denied, suspended, or terminated;
19. Receive 30 calendar days' notice of any changes in services from the agency, except in emergency situations wherein a participant's health and safety is at risk;
20. Look at and have an explanation of any bills for services paid by the DOH-DDD;
21. Have privacy and confidentiality in treatment and care;
22. Have access to an interpreter, if needed;
23. Be free from being restrained or secluded; and
24. Refuse from being included in research projects.

1.7 - PARTICIPANT SAFEGUARDS

Sub-sections A, B, and C below focus on positive behavior supports and the Behavior Support Plan (BSP). DOH-DDD promotes a positive behavior support (PBS) approach in all relationships with waiver participants. Practices and procedures must allow people to engage in adaptive and socially desirable behaviors that lead to meaningful and productive lives. A positive approach assumes that all behavior has meaning and that a person's behavior can be a means to communicate a need or a manifestation of a medical or clinical issue such as trauma. DOH-DDD is committed to eliminating the use of aversive procedures and restrictive interventions. Seclusion is prohibited. Restrictive interventions are only to be utilized in emergency situations where there is an imminent risk of harm to self or others. Less restrictive interventions must always be attempted first, and documentation must demonstrate that restrictive interventions are not effective. The required additional safeguards include training, supervision, reporting, documentation, debriefing, and monitoring by qualified individuals.

All restrictive interventions must be part of a formal BSP that is developed by a licensed professional or qualified designee in accordance with Hawai‘i state law following the completion of a Functional Behavioral Assessment (FBA). The BSP shall include interventions that always starts with the least restrictive intervention possible.

There are three DOH-DDD Policies & Procedures (P&P) that support the use of PBS for all participants:

- P&P #2.01 *Positive Behavior Supports* (see Appendix 4A)
- P&P #2.02 *Restrictive Interventions* (see Appendix 4B)
- P&P #2.03 *Behavior Support Review* (see Appendix 4C)

Please refer to the above-mentioned P&Ps which describe the requirements for Medicaid I/DD Waiver Providers. DOH-DDD will provide overview training to Providers on these P&Ps, and

the practices that support the emphasis on a positive behavior support approach with all participants. Providers must implement training for its staff to use positive behavior support procedures and practices. DOH-DDD will monitor Providers for adherence to these P&Ps.

A. Positive Behavior Supports

Historically, many interventions used for people with I/DD have been intrusive, focused primarily on punitive consequences, and/or ineffective in producing meaningful changes. PBS are preferable because they focus on understanding what maintains an individual's challenging behavior and how to change it, and are more effective in improving quality of life for people with behavioral challenges. While the goal of DOH-DDD P&P #2.01 Positive Behavior Supports is to safely support participants who may engage in challenging behaviors, a core purpose is to promote participants' engagement with integrated activities in the community.

The fundamental features of this policy include a foundation built on person-centered values, a commitment to outcomes that are meaningful, and services individualized to each participant's unique interests and strengths. The primary purposes of this policy are to commit to approaches that embrace the unique strengths and challenges of each participant and engage each participant's circle of support as partners in developing and implementing PBS approaches using least restrictive interventions. When a participant presents behavior that puts them at imminent risk of hurting themselves or others, PBS shall be used, whenever possible, to decrease the behaviors that pose a risk. When PBS techniques have been used and documentation demonstrates that less restrictive interventions were not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary (refer to P&P #2.02, Restrictive Interventions). Behavioral Support Plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others. Ultimately, P&P #2.01, Positive Behavior Supports, sets forth the core values of supporting participants to the best of their abilities by expanding opportunities and enhancing quality of life using PBS approaches.

Full definitions and procedures for P&P #2.01, Positive Behavior Supports can be found in Appendix 4A.

B. Restrictive Interventions Including Prohibited Restricted Interventions

DOH-DDD P&P #2.02, *Restrictive Interventions,* details the guidelines when using restrictive interventions and can be found in Appendix 4B. The purpose of this policy is to ensure that participants are supported in a caring and responsive manner that promotes dignity, respect, trust and is free from abuse. Participants have all the same rights and personal freedoms granted to people without disabilities.

When a participant presents behavior that put them at imminent risk of hurting themselves or others, positive behavior supports (PBS) must be used, whenever possible, to decrease the behaviors that pose a risk and prevent the need for restrictive interventions (P&P #2.01, *Positive Behavior Supports*). When PBS techniques have been used and documentation demonstrates that they are not effective in resolving the immediate risk of harm, restrictive procedures that involve temporary restrictions may be necessary.

Restrictive interventions are only to be utilized for the protection of the participant and others from imminent risk of harm. These interventions are the least desirable approach to supporting participants and must be detailed in a formal BSP that is developed by a licensed professional or qualified designee in accordance with Hawai‘i state law following the completion of a Functional Behavioral Assessment (refer to pages 4 - 7 of P&P #2.01, *Positive Behavior Supports*, for specific procedures and requirements when developing a formal BSP).

DOH-DDD P&P #2.02, *Restrictive Interventions*, dictates that restrictive interventions are only to be used when a participant's behavior(s) pose an imminent risk of harm to themselves and/or others and less restrictive interventions have been attempted with documentation demonstrating their limited effectiveness at reducing and/or replacing the challenging behavior. The restrictive interventions utilized must be the least restrictive method to address the challenging behavior and shall be terminated when there is no longer an imminent risk of harm and/or a less restrictive intervention would achieve the same purpose. The fundamental features of this policy specify that restrictive interventions are as follows:

- only meant to address situations of imminent risk of harm.
- not to be used as threats or punishment to change behavior as participants have the right to be free from any restrictive intervention imposed for the purpose of discipline, retaliation and/or staff convenience.
- not therapeutic in nature nor designed to alter behavior in a long-term manner so should not be utilized with this intent.

1. Formal Behavior Support Plan (BSP)

   When behavioral data and the Individualized Service Plan (ISP) team confirms an imminent risk of harm to the participant and/or others, and it is documented that less restrictive interventions have been attempted and deemed ineffective at decreasing the risk of harm, a formal BSP with restrictive intervention(s) must be developed and contain the following features.

   a. PBS methods are the primary interventions to safely address challenging behaviors and increase a participant's independence and integration into community activities. The

Individual Plan (IP) must incorporate approaches that align with the BSP methods when appropriate. The IP approaches and strategies do not repeat the BSP methods but should demonstrate that approaches and strategies are consistent with the BSP methods.

b. Restrictive interventions that are only used to protect the participant and/or others from imminent risk of harm after less restrictive interventions have been applied and deemed ineffective at addressing the challenging behavior, with appropriate documentation demonstrating their ineffectiveness.
c. The specific conditions that warrant the use and removal of a restrictive intervention, or the use of a less restrictive intervention must be specified. A timeframe should be provided for which termination of a restrictive intervention should occur.
d. Specific information on how to apply and remove each restrictive intervention is addressed, including photographs and other descriptions detailing how the restrictive intervention should be applied, maintained, and removed.
e. Detailed information on how the author of the BSP plans to train all members in the participant's circle of support prior to their independent use of a restrictive intervention as well as how documentation will be maintained regarding how these individuals respond to the training (e.g., are they able to independently apply interventions appropriately).
f. Information regarding how the restricted right(s) of the participant will be restored following the use of a restrictive intervention is addressed.
g. Strategies to prevent or minimize the challenging behaviors from occurring as well as identification of replacement skills that serve the same function as the challenging behavior will be taught to the participant.
h. Goals that enhance the participant's overall quality of life are included, so that objectives are not limited to addressing challenging behaviors only.
i. Specific instructions are included on how documentation and/or data collection should be completed following the use of a restrictive intervention for the purpose of monitoring and evaluating the use and effectiveness of an intervention.
j. Specific information is included on how relevant data will be collected and analyzed by the licensed professional or qualified designee who developed the BSP in accordance with Hawai‘i state law. The purposes of the data analysis is to provide ongoing

monitoring of the implementation of the BSP, analysis of the effectiveness of the interventions included in the BSP, oversight of the accuracy of data collection methods by individuals implementing the BSP, and assessment of the need for and provide retraining on the BSP, if necessary.

k. The plan must include the process for debriefing within 24 hours of the initial application of the restrictive intervention.

l. Adjustments to the BSP may be made by the author of the BSP or qualified designee, if needed.

m. A detailed plan for the eventual elimination of the restrictive intervention must be included.

2. Training in BSPs with Restrictive Interventions

a. All paid Medicaid I/DD Waiver personnel who will implement and/or oversee the implementation of the formal BSP must meet General Staff Requirements (refer to Section 2) and DOH-DDD Service Specific Performance Standards (refer to Section 3).

b. Prior to implementing a formal written BSP that includes a restrictive intervention, all staff implementing and/or supervising the BSP must complete a nationally-recognized curricula approved by the DOH-DDD for positive behavior supports/safe interventions and complete an initial in-person training that includes all aspects of the BSP including, but not limited to, the positive behavior support approaches, interventions, documentation and monitoring procedures, and techniques for teaching replacement skills proposed for use in the BSP. The initial training in implementing the BSP shall be completed by the author of the BSP and any follow-up trainings and/or ongoing monitoring of the BSP shall be completed by the author of the BSP or his/her qualified designee.

c. Individuals who implement a restrictive intervention shall be trained, monitored, and evaluated on an ongoing basis to ensure appropriate application of the restrictive intervention both prior to and throughout their independent application of the intervention.

d. Documentation of all training(s) on the individualized BSP shall be maintained in the Provider agency's files. Training records shall be available for review by the DOH-DDD.

3. Prohibited Restrictive Interventions

The procedures that are prohibited and shall not be used with participants include but are not limited to the following:

a) Seclusion

b) Aversive procedures involving:

1) Electric shock (excluding electroconvulsive therapy);

2) The non-accidental infliction of physical or bodily injury, pain, or impairment, including but not limited to hitting, slapping, causing burns or bruises, poisoning, or improper physical restraint;

3) Unpleasant tasting food or stimuli; and

4) Contingent application of any noxious substances which include but are not limited to noise, bad smells, or squirting a participant with any substance that is administered for the purpose of reducing the frequency or intensity of a behavior.

c) The following types of restraints:

1) Restraints that cause pain or harm to participants. This includes restraint procedures such as arm twisting, finger bending, joint extensions or head locks;

2) Prone Restraints;

3) Supine Restraints;

4) Restraints that have the potential to inhibit or restrict a participant's ability to breathe; excessive pressure on the chest, lungs, sternum, and/or diaphragm of the participant; or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;

5) Restraint Chairs;

6) Restraint Boards;

7) Any maneuver that involves punching, hitting, poking, or shoving the participant;

8) Straddling or sitting on the torso;

9) Any technique that restrains a participant vertically, face first against a wall or post; and

10) Any maneuver where the head is used as a lever to control movement of other body parts.

d) Interventions involving:

1) Verbal or demonstrative harm caused by oral, written language, or gestures with disparaging or derogatory implications;
2) Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation;
3) Denial of food, beverage, shelter, bedding, sleep, physical comfort or access to a restroom as a consequence of behavior;
4) Restricting or disabling a communication device;
5) Placing a participant in a room with no light;
6) Overcorrection; and
7) Removing, withholding or taking away money, incentives or activities previously earned.

Specific procedures regarding Restrictive Interventions are found in Appendix 4B.

C. Behavior Support Review

The purpose of Behavior Support Review is to ensure that PBS methods are the primary interventions utilized when working with DOH-DDD participants and that appropriate safeguards and oversight are in place when restrictive interventions are proposed for use in a BSP. The DOH-DDD Behavior Support Review Committee (BSRC) may review BSPs that include a restrictive intervention and may provide recommendations to ensure appropriate, effective, and safe application of an intervention by service Providers as per P&P #2.03, *Behavior Support Review*.

P&P #2.03 describes how the DOH-DDD Behavior Support Review will review BSPs that propose the use of restrictive interventions to address challenging behaviors that pose an imminent risk of harm to the participant or others.

Full procedures for authority and operations of the BSRC are found in P&P #2.03, *Behavior Support Review,* in Appendix 4C.

D. Nursing Assessment and Delegation

Participants whose health and safety needs include nursing tasks, performed during waiver service hours, must receive a Nursing Assessment by a Provider to help inform the person-centered planning process. The Nursing Assessment must be completed by a Registered Nurse

(RN), who is licensed in the State of Hawai‘i, in accordance with HRS §457-2.5 and §457-7, and include, but is not limited to, the following:

1) identification of tasks that may be delegated, based on the participant's needs and circumstance,
2) assessment of the participant's circumstance,
3) assessment of the person(s) that may perform the delegated task(s),
4) supervision/monitoring requirements, and
5) recommendation for hours needed to complete nurse delegation requirements (recommended hours will be reviewed and considered for authorization by the DOH-DDD).

See Section 4.18 – Training & Consultation for more details.

1. Nursing tasks that may be delegated, performed by a direct support worker or consumer-directed employee during waiver service hours, must be delegated by an RN in accordance with HRS §457-7.5. The delegating RN will determine whether tasks can be delegated and who can perform those tasks under nurse delegation. A Licensed Practical Nurse (LPN) shall not develop a delegation plan. The Nurse Delegation plan(s), training and skills verification must meet the minimum requirements specified in Section 4.18 and be included in the participant's record.

2. If a participant receives an RN assessment that identifies nursing tasks that may be delegated during Residential Habilitation (ResHab) services, the licensed/certified caregiver delivering the service must meet state delegation requirements. Any nursing task performed by a licensed/certified caregiver for participants who live in their home must be in accordance with and adhere to their licensure or certification rules.

3. If the person delivering direct care services during waiver service hours is an RN, any nursing task must be performed in accordance with the provider agency, licensure and certification rules.

4. Table 1.7-1 provides examples of nursing tasks that may be delegated and tasks that licensed nurses must perform. The table is a guide; the RN determines whether tasks can be delegated and who can perform those tasks under nurse delegation.

TABLE 1.7-1: Nursing Tasks

Examples of Nursing Tasks that may be Delegated *(the delegating RN will determine whether tasks can be delegated and who can perform those tasks under nurse delegation)*	**Tasks for Nurses Only (LPN or RN)** *(subject to review by DOH-DDD prior to authorizing Private Duty Nursing)*
N/A	Assessment, evaluation, and teaching must be completed by the RN only and must not be delegated to an LPN
N/A	Accepting telephone (or other non-face-to-face) orders from professionals with prescriptive authority must be done by the RN only and must not be delegated to an LPN
N/A	Intravenous (IV) medications or Peripherally Inserted Central Catheter (PICC line) must be done by RN only and must not be delegated to an LPN
Scheduled medications administered by Provider agency worker or consumer-directed employee [routes: oral, gastrostomy, jejunostomy, ocular, otic, inhaled, nebulized, rectal, topical/transdermal]	Intramuscular (in the muscle) injection – non-prepared
All PRN medications administered. NOTE: Verbal RN consult must occur prior to administration of any PRN narcotic analgesic. Verbal RN consult must occur prior to administration of any medication prescribed for the purpose of behavior control.	PRN medication administered via intramuscular injections
Diastat (Valium) [route: rectal suppository] Prepared medication. Requires order and specific individualized seizure protocol from the professional with prescriptive authority (see Appendix 4E, Seizure Action Plan).	N/A
Prepared subcutaneous (under the skin) dose of insulin with no recent history of hypoglycemia Prepared intramuscular (in the muscle) epinephrine (e.g., Epi-Pen) given as first aid	Sliding scale insulin
N/A	Non-prepared subcutaneous (under the skin) injection (the drawing up of the medications is not delegated)

Examples of Nursing Tasks that may be Delegated *(the delegating RN will determine whether tasks can be delegated and who can perform those tasks under nurse delegation)*	**Tasks for Nurses Only (LPN or RN)** *(subject to review by DOH-DDD prior to authorizing Private Duty Nursing)*
Oropharyngeal suctioning - Insertion of a rigid suction catheter or Yankauer into the mouth and pharynx for the purpose of removal of excess saliva or mucous secretions and foreign material (vomitus or gastric secretions) from the mouth and throat not to extend beyond the pharynx	Nasotracheal and endotracheal suctioning - (usually in acute care) A sterile technique requiring insertion of a soft, sterile flexible catheter into the nose, pharynx, trachea and the endotracheal or tracheostomy tube for artificial removal of excess secretions from the lower airway. Tracheostomy suctioning - Intermittent insertion of a sterile soft catheter into the tracheostomy (connected to suction apparatus) for artificial removal of excess mucous secretions from the trachea and lower airway. Tracheostomy Tube Change
Cough Assist machine	N/A
Chest Percussion – manual or via vest	N/A
Gastrostomy (GT) feedings - Liquid nutrition provided into a surgically implanted tube in the stomach. May be intermittent (bolus) or continuous via pump. Jejunostomy (JT) feedings – Liquid nutrition provided into a surgically implanted tube in the jejunum (the small bowel).	Total Parenteral Nutrition (TPN) - Parenteral nutrition, also known as intravenous feeding, is a method of getting nutrition into the body through the veins. While it is most commonly referred to as total parenteral nutrition (TPN), some patients need to get only certain types of nutrients intravenously
Nebulized meds - Liquid medications prescribed to be administered via vaporization into a fine spray	N/A
General first aid	N/A
Dressing changes without assessment • Clean • Sterile • Stoma	Sterile dressing changes requiring wound assessment
Glucose monitoring	N/A
Oxygen therapy with specific parameters from prescriber	Oxygen therapy that requires assessment and intervention by a nurse due to instability

Examples of Nursing Tasks that may be Delegated *(the delegating RN will determine whether tasks can be delegated and who can perform those tasks under nurse delegation)*	**Tasks for Nurses Only (LPN or RN)** *(subject to review by DOH-DDD prior to authorizing Private Duty Nursing)*
Straight urinary catheterization or indwelling Foley catheter care Suprapubic catheter care	Foley catheter change under sterile technique
Other tasks not specified in this require use of the Nursing Delegation Decision Making Tree (see Appendix 4D).	N/A

E. Medication Management

5. Medication is defined as any over-the-counter, legend, or controlled drug.

    1) Over-the-counter drug means medicines sold directly to a consumer without a prescription from a healthcare professional.
    2) Legend drug means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider.
    3) Controlled drug substance means any drug or therapeutic agent–commonly understood to include narcotics, with a potential for abuse or addiction, which is held under strict governmental control, as delineated by the Comprehensive Drug Abuse Prevention & Control Act passed in 1970.

6. Nurse Delegation for Medication Assistance and/or Administration

    Medication assistance or administration can only be performed by a licensed nurse or as part of nurse delegation.

    Medication assistance includes, but is not limited to, any of the following steps:

    1) Placing the labeled container with the medication in the participant's hand,
    2) Placing the "pill organizer" with medications pre-arranged by the hour, day, or week in the participant's hand,
    3) Assisting the participant with opening the container and dropping the medication into the participant's hand when needed,
    4) Instructing or prompting the participant to take the medication,
    5) Assisting the participant to take the medication,
    6) Helping the participant to drink a liquid to swallow the medication, or
    7) Watching and observing the participant to ensure that the medication has been swallowed.

Medication administered by an LPN must be under the supervision of an RN. Direct support workers or consumer-directed employees who assist with or administer medications during waiver services hours can only do so when delegated by an RN in accordance with HRS §457-7.5.

Licensed/certified caregivers who assist with or administer medications for participants who live in their home can only do so when it is in accordance with and adheres to their licensure or certification rules.

Procedures for Adverse Event Reporting (see Section 1.8 Adverse Event Reporting and Section 2.6 Provider Agency Quality Assurance), including medication errors and unexpected reactions to drugs or treatment must be followed.

7. Medication Self-Administration

Participants can self-administer medications when they can demonstrate their ability to independently initiate the ingestion, inhalation, or injection of prescribed medications as evidenced by all the following listed below. A participant may use words, signs, pictures, assistive devices or other means of communication to demonstrate the ability to self-administer medications.

1) Ability to identify the medication,
2) Ability to state the reason for taking the medication,
3) Ability to state the prescribed dosage,
4) Ability to state the scheduled time, and
5) Ability to take the medication as prescribed means:
   i. the participant can physically take the medication without assistance or reminders from the worker. The participant is deemed to be able to self-administer the medication if he or she uses an assistive technology device for reminders to take the medication; or
   ii. the participant communicates the instructions to a worker using words, signs, pictures, assistive technology devices or other means of communication to accurately direct the worker to physically assist the participant with taking the medication.

Certification that the participant is independent in medication self-administration must be documented by a health care practitioner with prescriptive authority on an annual basis.

1.8 - CONSUMER DIRECTION

Under the Consumer-Directed (CD) option, the participant has Employer Authority over the direct support workers who provide Medicaid I/DD Waiver services. The participant functions as the common law employer and is responsible to: recruit, hire, train, schedule, supervise, and terminate direct support workers (if applicable). The CD option also provides the employer with Budget Authority to control an annual budget to fund the services. The employer may transfer dollars between most services under the CD option and determine the hourly pay of the workers within a specified pay range. Employers must be at least 18 years of age and responsible to manage the utilization of services within the annual budget.

If a participant is not able to self-direct services, a designated representative may be appointed to be the employer. The individual must be willing and able to perform the employer responsibilities and cannot be a paid employee or be compensated for the help provided to the participant. If the participant has a legal guardian, the guardian shall be the designated representative. If a legal guardian is unable to carry out the duties of an employer, the legal guardian may assist the participant to select a designated representative. However, to avoid a conflict of interest, the legal guardian and the designated representative cannot be paid as CD employees. A designated representative must be willing to be the legally responsible employer and carry out the functions of the employer.

Waiver services provided under the CD option have the same definition and purposes identified in Section 4, Service-Specific Performance Standards. The participant and legal representative, if applicable, are informed of this option during the ISP development process. The following Medicaid I/DD Waiver services can be consumer-directed:

- Chore
- Community Learning Services-Individual
- Non-Medical Transportation
- Personal Assistance Habilitation
- Respite

The participant may elect to receive any of the above-listed services through the CD option or may choose a combination of the CD option and Waiver Provider-delivered services.

Waiver services using the CD option must be implemented as authorized in the participant's ISP. Specific employer responsibilities and procedures are detailed in the Consumer-Directed Option Overview and Requirements Employer Handbook. The CD employer is required to meet all requirements detailed in the Employer Handbook.

The DOH-DDD has contracted with a Financial Management Service (FMS) organization to assist the participant/designated representative to:

- manage the funds in a CD budget;
- facilitate the employment of staff by serving as a Fiscal/Employer Agent (F/EA) to process payroll, withhold and file taxes, and make payment to appropriate tax authorities; and
- perform fiscal accounting and make expenditure reports available to the participant/designated representative and DOH-DDD.

The F/EA services from the FMS organization provides the participant with a high degree of choice and control over workers as the common law employer while reducing the employer-related burden of managing payroll tasks. The F/EA also provides a safeguard for the participant by ensuring all taxes and Department of Labor requirements are met.

The CD employer is required to meet the requirements, procedures and timelines of the FMS organization and be responsible to ensure each employee is compliant with procedures. This will support the employer to comply with federal and state regulations. In addition, the employer is responsible to provide training and a safe work environment for the employee.

The CD employee must be 18 years of age and meet the requirements identified in Table 2.2-1 General Staff Qualifications and Requirements for Provider Staff. The CD employer must train the employee to implement services on the ISP before Medicaid funds can be paid for worktime. Any special employee qualifications or training must be documented on the Action Plan. The criminal history record check requirements must be completed before the employee is approved to start work.

The CD option provides the participant with flexibility and control over their services. This is derived from Employer Authority over the employee who provides Waiver services and Budget Authority over the dollars to fund the services. Employers must manage expenditures to ensure the annual budget for services under the CD option will last the duration of the ISP.
The employer may determine the hourly wage or pay of employees (within a range determined by the FMS) and reallocate dollars between most services under the CD option. The reallocation is initiated by the employer and subject to:

- Inclusion of the services in the ISP
- Use of the services as documented in the ISP
- Available dollars in the annual budget

Given the authority under the CD option, the employer has responsibility to fulfill the duties of the legal employer and be accountable to use public dollars in a judicious manner. The FMS assumes liability for the services they provide regarding payroll and taxes. However the

employer has liability arising from non-compliance with FMS procedures and inability to meet employer responsibilities. Such actions may result in termination from the CD option with services to be accessed from a provider agency. Termination from the CD option is not subject to appeal since services are still available from provider agencies.

1.9 - APPEAL RIGHTS OF PARTICIPANTS

The participant, or the legal representative if applicable, will receive a Notice of Action (NOA) from the Case Management Branch when services are being decreased, suspended, terminated, or denied, or when participants are being suspended or discharged from the Medicaid I/DD Waiver. The participant or the participant's legal representative has the right to request an appeal of the NOA. Waiver services currently authorized continue while the appeal is pending.

The participant or legal representative may ask for one or more of these options:

1. An informal review with staff from the DOH-DDD,
2. An administrative hearing from the DOH, and/or
3. An administrative hearing from the DHS.

A. Informal Review

1. The participant or legal representative is given an opportunity to present information to members of the DOH-DDD staff to show that the proposed action is incorrect. They can choose to explain circumstances about the participant's needs and situation that the DOH-DDD staff may not be aware of and that might result in a different action. After the informal review is held, the action may be affirmed, modified, or reversed by the DOH-DDD.

2. The written request for an Informal Review must be submitted to:

   Hawai'i State Department of Health
   Developmental Disabilities Division
   Outcomes and Compliance Branch
   Consumer Complaints Resolution Unit
   2201 Waimano Home Road, Hale A
   Pearl City, Hawai'i 96782

B. Administrative Hearing from the DOH and/or DHS

1. The participant or legal representative may present relevant evidence and argument on the issues raised. The participant may examine and cross-examine witnesses and present exhibits. After the administrative hearing is held, the action may be affirmed, modified, or reversed by the Hearings Officer.

2. The written request for administrative hearing **from DOH** must be sent to:

   Hawai‘i State Department of Health
   Director of Health
   P.O. Box 3378
   Honolulu, Hawai‘i 96801

3. The written request for administrative hearing **from DHS** must be sent to:

   Hawai‘i State Department of Human Services
   Administrative Appeals Officer
   P.O. Box 339
   Honolulu, Hawai‘i 96809

SECTION 2:
QUALITY MANAGEMENT OVERVIEW AND REQUIREMENTS

2.1 – OVERVIEW OF STATE'S OBLIGATIONS TO ADDRESS QUALITY OF CARE

A. The 1915(c) Waiver Obligates Each State To Meet All Waiver Assurances

CMS requires each State's 1915(c) waiver to have a quality system that includes developing, measuring, and monitoring performance indicators for each waiver assurance. States are responsible for monitoring the quality of their own programs and for developing systems to continuously monitor whether the State is meeting the assurances. Providers have an important role in developing and implementing quality systems within their organizations as part of the waiver's quality of care requirements.

CMS also expects States to have strategies to correct any problems uncovered by their monitoring systems. States must provide evidence to CMS that they are meeting the assurances. CMS examines the evidence submitted, issues a report of findings, and gives the State time to correct problems. In considering waiver renewal applications, CMS must be confident that the measures the State has taken or plans to take will correct the problems. If all quality of care problems are not addressed, CMS can require the State to implement a corrective action plan with additional evidence.

B. The State Must Demonstrate Ongoing Compliance with Six Assurances In Order To Operate A 1915(c) Waiver

Waiver Assurances:

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

2. Level of Care
   Assurance: The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating applicant's/waiver participant's level of care consistent with the care provided in a hospital, nursing facility, or ICF/IID.

3. Service Plan
   Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

4. Qualified Providers
   Assurance: The State demonstrates that it has designed and implemented an adequate system for assuring all waiver services are provided by qualified providers.

5. Health and Welfare
   Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

6. Financial Accountability
   Assurance: The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

C. Quality of Care Assurances In 1915(c) Waiver

Of the assurances listed above, three (3) assurances specifically relate to quality of care in every 1915(c) waiver. To meet these assurances, States must demonstrate that they have systems to effectively monitor:

1. Assurance: The adequacy of service plans
   Each person must have a written service plan based on an assessment of the individual's needs.

2. Assurance: The qualifications of providers
   Each person must be served by qualified providers.

3. Assurance: The health and welfare of participants
   States must have necessary safeguards to protect the health and welfare of participants.

Requirements for Hawaii's 1915(c) waiver providers in each of these three areas (service plans, provider qualifications, and health and welfare) are described in these standards.

More information on Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers can be found at:

https://www.medicaid.gov/sites/default/files/2019-12/3-cmcs-quality-memo-narrative_0.pdf

2.2 – FEATURES OF DOH-DDD's QUALITY MANAGEMENT SYSTEM

"System builders need to develop structures that measure quality, that provide feedback loops, and that have response (i.e., quality improvement) capabilities."

(Building Systems of Care: A Primer, by Sheila Pires)

The 1915(c) waiver requires DOH-DDD to operate a quality management program that monitors all levels of the service system. DOH-DDD has developed accountability structures, practices and methodologies to measure quality and implement necessary improvements. Valid data that measures service quality and service system functions are needed to tell us how we are

performing in the here and now, as well as over time (trend data) in order to help us make decisions and program adjustments.

A brief overview of DOH-DDD's quality system is described below. DOH-DDD monitors quality and conducts continuous quality improvement through:

A. Aligning Values and Services

Waiver services are designed to support Possibilities Now! for each individual served by DOH-DDD.

B. Continuous Monitoring

- *Role of Staff Units in DOH-DDD*
  There are a number of staff and staff units in DOH-DDD that monitor performance on a continuous basis. Examples are staff that maintain the Adverse Events system, a committee that conducts mortality reviews, and Provider Monitors that review performance on an ongoing basis. The Outcomes and Compliance Branch leads DOH-DDD's quality management efforts, but staff across DOH-DDD are involved in quality monitoring and producing data reports. Supervision of staff is also linked to review of data and performance monitoring.

- *Reporting on Waiver Assurances*
  On an annual basis, DOH-DDD and MQD submit a report to CMS that identifies all areas of performance on waiver assurance when the overall finding was below 86%. The report must also describe DOH-DDD's analysis to understand why performance was below the CMS minimum standard and what actions are being taken to improve performance for the following year.

C. Established Structure to Review Quality

- *Quality Assurance and Improvement Program (QAIP)*
  DOH-DDD's QAIP provides a systematic process for reporting on and reviewing quality across DDD. It is made up of three subcommittees: Quality Services and Care, Safety and Well-Being, and Service Provision and Access, and a Steering Committee. These committees meet quarterly to review performance measures and quality data that are part of the Annual QAIP Work Plan. When an opportunity for improvement is identified by the subcommittees, a recommendation is made to the QAIP Steering Committee, which reviews and refines improvement recommendations. Improvement recommendations are approved and assigned by the DOH-DDD Management Team. Reporting on status of

improvement actions are monitored by the QAIP. Remeasurement and evaluation is an important part of the process as it determines if improvement actions had intended results.

- *Specific Methodologies and Tools*
  DOH-DDD uses core methodologies to analyze data and select improvements including trend analysis and root cause analysis. This allows for selecting areas of risk that require improvement. An example is review of mortality data indicated that aspiration pneumonia was among the leading causes of death. DOH-DDD implemented training on prevention of aspiration pneumonia system-wide.

D. Developing a Culture of Quality

Developing a culture of quality in DOH-DDD involves a systems approach that sets clear performance expectations, requires systematic and ongoing data collection and analysis, and uses performance data to drive decision-making and improvements. Key strategies include engaging with DOH-DDD staff at all levels of the organization through subcommittee meetings, tracking implementation and evaluating improvement activities, training on the QAIP, and leadership by DOH-DDD's Management Team to ensure accountability and quality across the service system.

2.3 - ROLE OF PROVIDERS IN IMPLEMENTING QUALITY MANAGEMENT (QM) PRACTICES

Ensuring quality in organizations that provide services is everyone's responsibility. The more we intentionally build cultures of quality in each Provider agency and have shared responsibility for quality by each person that provides service, the better we become at connecting everyone to the mission of providing quality services. Ensuring high quality services helps each agency to meet the highest expectations of your stakeholders and assures satisfaction with services by participants and families.

Quality management provides a structure and system that integrates basic business management skills, a desire to improve services, and technical tools that are focused on a continuous process and outcome improvement. QM implementation is a necessary part of not only operating quality services, but in helping our entire system shift to increasing person-centered practices and measuring our results.

Many Providers have existing QM systems such as those required by accreditation. The requirements below can be integrated into your existing efforts. In other cases, developing systematic QM practices may be a new development area. DOH-DDD will be providing technical assistance and training.

A. Providers Are Expected to Develop and Implement an Internal Quality Management Program.

Each Provider is required to evaluate their performance on the CMS assurances that relate to quality of care and provider specific performance measures. This is achieved by developing and implementing a continuous quality improvement/quality management program. While compliance with CMS and Waiver Standards is very important, a successful quality program can have a significant impact on improving the overall functioning of an organization, the delivery of services and outcomes for participants.

1. Timeline

   By June 30, 2024 all Providers must complete the activities described below to assure your QM program identifies issues that impact quality of care and opportunities for improvement. Through an ongoing and systematic approach to quality, provider agencies can improve the delivery of services and outcomes for participants. Refer to the "Staging the development" section for activities to be completed during each of the next three years. Providers may integrate the QM requirements described below into their existing quality management program, including QM programs that meet accreditation standards.

2. Staging the development of your QM program

   As mentioned above, many Providers may only need to refine and adjust their quality management program to address the requirements specified in the standards. Other Providers may need to re-design or develop a quality management program that includes the requirements listed below. The purpose of staging the requirements during the first three years of the current waiver is to enable all providers to have a quality management program in operation by June 30, 2024.

   a. The first year of the Waiver, ending June 30, 2022 is to establish your QM program structure, define its purpose, leadership, and priority areas to make programmatic improvements. The first year is also for learning, training, and building a culture of quality.

   b. The second year of the Waiver, ending June 30, 2023 is for beginning your baseline measurement and identifying opportunities for improvement. It is also for designing your improvement projects.

      DDD has selected several basic areas that each Provider must conduct monitoring and identify any opportunities to improve performance for:

      1) AER plans of action,

2) DSW training on mandatory topics, and

3) IP quality and implementation.

These areas align with the waiver sub-assurances, as well as DDD provider monitoring activities.

c. During the third year of the Waiver, ending June 30, 2024, you will have started implementing your improvement projects and evaluating the impact of your improvements. During this year and on an ongoing basis, you will be making programmatic changes or adjustments to sustain your desired performance.

DDD will provide training and technical assistance over the three years on the basics of quality management in HCBS Waiver programs. DDD will continue to provide oversight of Waiver assurances including the quality of care for all Waiver participants. Providers will be required to attend quality management trainings.

B. Quality Management Program Requirements

1. Waiver Year 1

During the first year of the waiver, ending June 30, 2022, the Provider Quality Management (QM) Program should complete the following activities to establish the group, define the purpose and develop a written description of your QM Program:

a. Establish a group responsible for quality.

The group can be a new quality council, an existing quality assurance committee, or part of the executive management group's standing agenda. Engage a broad group of stakeholders. The group must include family members, direct support workers and service supervisors. Members of agency boards can also be included.

Define membership, roles and responsibilities. Include who is responsible for the QM program in your organization.

b. Define the purpose of the QM Program.

Establish the purpose for the QM program in alignment with the organization's vision, mission and goals. The overall purpose of your quality group should be to identify meaningful performance and outcome measures to track, and to set priorities for quality improvement.

The purpose of your QM program will include:

1) Identify goals for the QM program including identifying outcomes and performance measures,
2) Identify types of data to be gathered and data sources,
3) Describe frequency of data collection,
4) Analyze and assess performance based on review of data,
5) Prioritize quality improvement actions, and
6) Evaluate implementation of improvements and effectiveness of your quality management plan.

Commit to using findings in decision making regarding priorities, distribution of resources and other organizational changes.

Core questions for your agency to answer are:
1) How will the participants served by the organization be better off as a result of the QM program?
2) In what ways will the QM program help to develop and improve staff skills in delivering quality services to participants?

c. Develop the written description of the QM Program.

The written QM Program plan creates a framework for managing quality within your agency in a comprehensive, consistent and continuous manner. The written plan must include, at a minimum:

1) Describe the purpose.
2) Describe in writing the systematic process for monitoring quality and the QM structure.
3) Describe roles and responsibilities for parts of the QM program throughout the organization.
4) Develop the policies and procedures (P&P) to ensure sustainability of the QM program.
5) Describe, as applicable, how your agency's board, leadership, managers, staff and key stakeholders will be trained on QM concepts, the role of each designated group and the agency's QM program in an ongoing manner.
6) Describe how findings and improvement actions will be documented (meeting minutes, etc.).
7) Describe how QM tools will be used to analyze data:
    i. There are a number of basic tools, or methods, that can be used to understand your quality data, detect root causes for issues and make improvements. Methods can include cause and effect diagrams, flowcharts, or other tools.

ii. Select tools that your organization will use to understand your quality data and make desired improvements. The key to successful problem resolution is the ability to identify the problem, use the appropriate tools based on the nature of the problem, and to implement and communicate solutions with your team.
iii. DOH-DDD will be conducting training on QM tools, or there are many widely available resources that can be accessed.

Providers will be required to submit documentation to DOH-DDD that the QM Program was developed (establish the group, develop the purpose and write the QM plan) by June 30, 2022.

2. Waiver Year 2

During the second year of the waiver, ending June 30, 2023, the Provider Quality Management (QM) Program should complete the following activities to collect and use data, select areas for improvement, and implement improvements.

a. Collect and use data.

Define what is important to monitor. Engage with your stakeholders, including participants, families and staff delivering services to help determine what is most important to improving quality. Include your Customer Satisfaction data that you are required to gather. Select areas to monitor and performance measures for measuring quality. It is important to focus on a few strong measures than to try to address too many at once. Providers must select at least one measure that is specific to their organization, in addition to the DDD areas.

1) DDD has identified key areas that all providers must conduct monitoring for. Determine your baseline performance for the following:

i. AER plans of action
ii. DSW training on mandatory topics
iii. IP quality and implementation

2) Identify data your organization already collects and determine how it can be useful in the QM program. Select areas and performance measures in areas that are important to improve. Some examples of areas to focus improvements on are staff injuries, staff turnover, customer satisfaction, and others.

3) In addition to using data your organization already collects, you may identify important areas that will require you to develop new data collection or tracking. Examine the areas of risk and priorities for your agency.

b. Select Areas for Improvement.

Your selection(s) for which areas to work toward performance improvement will be based on what your data are telling you.

1) As a result of review of your quality data, select areas that your team wants to prioritize for improving.

2) Select areas that are in line with your agency's priorities, are important to your participants, are manageable (can be accomplished in about 3-6 months) and will have a measurable impact.

c. Implement Improvements.

Implementation involves planning, testing and spreading improvement strategies (changes).

1) Start with a small-scale demonstration or small test of change. This will allow for refinement of new processes, demonstrate their impact, and build support for the change.

2) Decide on the goal, strategies, actions of your change.

3) Monitor your improvement and make needed adjustments along the way.

4) Learn about ways to implement a quality improvement process.

There are many resources including:
https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/4-approach-qi-process/index.html#4b

Providers will be required to submit documentation to DDD that the QM Plan was implemented (collect and use data, select areas for improvement, and implement improvements) by June 30, 2023.

3. Waiver Year 3 and Ongoing

Starting in the third year of the waiver, ending June 30, 2023, and on an ongoing basis, the Provider Quality Management (QM) Program will complete the following activities to measure and evaluate the impacts of your QM actions, and to sustain your QM practices.

a. Measure and evaluate the impact of your improvement.

This step is re-measurement of performance based on the actions taken. Use your data to identify what worked and what did not work.

1) Evaluate with your team including how the actions might be adjusted, added to, and sustained. Include in your evaluation:

    i. Test the acceptance and/or adherence to new or revised practices.
    ii. Examine how and how much the new practices are affecting the delivery of person-centered services.
    iii. Assess the impact on outcomes for participants.

2) For quality strategies that worked successfully, your organization will identify ways to spread the improvement throughout the organization, as well as how to maintain that level of quality over time.
3) Choose a re-measurement period for the goal you have taken action to improve and generate a new performance goal. Training will be provided on how to do this.

b. Choose other areas to improve through continuous quality improvement.

Providers will be required to submit documentation to DDD that the QM Plan's selected activities were measured and evaluated by June 30, 2024.

SECTION 3:
MEDICAID I/DD WAIVER PROVIDER GENERAL REQUIREMENTS AND STANDARDS

3.1 - PARTICIPATION AS A MEDICAID I/DD WAIVER PROVIDER

A. General Information

Payment for covered goods, care, and services must only be made to Providers that have been recommended by DOH-DDD and approved by DHS-MQD to enter into a Medicaid Provider Agreement for the Medicaid I/DD Waiver. The following pertain to any exemption that a Provider requests from the Waiver Standards requirements:

1. Requests for exemptions from the Waiver Standards by a Provider agency must be submitted in writing to the DOH-DDD.
2. Requests for exemptions shall be denied if the exemption will create a hazard to health or safety as determined by DOH and DHS.
3. Exemptions granted by DOH-DDD and DHS-MQD, whether expressed or implied, must be documented and must not be transferred from one Provider agency to another.

B. Limitations/Exclusions/Restrictions

The following situations are service limitations, exclusions, and restrictions to the use of the Medicaid I/DD Waiver:

1. Services under the Medicaid I/DD Waiver are used only when mandated resources have been sought and secured (e.g. Hawai‘i Medicaid State Plan; Early Periodic Screening, Diagnosis and Treatment Services [EPSDT]; Division of Vocational Rehabilitation; and Department of Education), and family and community resources are not available.

2. Services paid through the Medicaid I/DD Waiver shall not be provided to a minor child, under 18 years of age, by the parent, stepparent, or legal guardian of the minor or to an adult participant by their spouse.

3. Non-billable Activities
   Examples of activities performed by staff that are not billed to the Medicaid I/DD Waiver include, but are not limited to:
   a. Attendance at general staff in-service training;
   b. Preparation and submission of progress reports; and
   c. Preparation of billing statements.

C. Applying For Or Amending Participation As A Medicaid I/DD Waiver Provider

1. License or Certification

   In accordance with Hawai‘i State law, licensed or certified workers must maintain their license or certification to practice within the scope of his/her profession. Permits, temporary licenses or any form of license or permit that requires supervision of the licensee do not serve to qualify as an eligible provider of services under the Hawai‘i Medicaid Program.

2. Medicaid I/DD Waiver Proposal Application and Addendum Application

   a. New Provider Applicants

      Any entity (individual, business, or organization) wishing to become a Medicaid I/DD Waiver provider must complete and submit a DOH-DDD Medicaid I/DD Waiver Proposal Application for review by the DOH-DDD.

      1) The Medicaid I/DD Waiver Proposal Application may be obtained from DOH-DDD's Community Resources Branch (CRB). See the Assistance Directory in Appendix 3.
      2) The applicant will receive acknowledgement of receipt of the submitted Medicaid I/DD Waiver Proposal Application. DOH-DDD will notify the applicant of the application status within ninety (90) business days of submission.
      3) The applicant has the responsibility to understand the HCBS final rule prior to submitting the application and the application must demonstrate full compliance.
      4) A site visit to the applicant's setting(s) may be scheduled as needed to assist in the review process and validate compliance with the HCBS final rule.
      5) The applicant must demonstrate in the application the plan to use an alternate EVV system for PCS that meets all federal and state requirements; or the plan to use the selected state-wide EVV system upon approval.
      6) If DOH-DDD recommends approval of the application, the recommendation will be submitted to DHS-MQD for final approval and execution of the written Provider Agreement.
         a) The applicant will be notified by the DOH-DDD and the applicant must complete the DHS-MQD application process online using the HOKU Provider Enrollment System at: https://medquest.hawaii.gov/en/plans-providers/become-a-medicaid-provider.html or complete Provider Enrollment Form (DHS 1139)

https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/hoku/REVISED_DHS1139_07-20_INTERIM.pdf (see Appendix 6). Options for submitting the DHS 1139 is by:

1) Email to HCSBInquiries@dhs.hawaii.gov and include "DHS 1139" in the Subject Line;
2) Fax to 808-692-8087; or
3) Mail to:
   Department of Human Services Med-QUEST Division
   Attention: Health Care Services Branch
   601 Kamokila Blvd., Room 506A
   Kapolei, HI 96707

b) A $500 application fee must also be paid through HOKU online or sent to DHS-MQD for processing.

c) All new applicants must email HCSBInquiries@dhs.hawaii.gov to request a temporary identification number for fingerprinting requirements. For instructions, see the Provider Enrollment Form (DHS 1139) https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/hoku/REVISED_DHS1139_07-20_INTERIM.pdf.

d) After the final approval process with DHS-MQD is complete, the new Provider must submit a copy of the approval letter with assigned Medicaid Provider ID# to DOH-DDD. The DOH-DDD will then contact the new Provider to facilitate access to the Provider Portal.

7) If DOH-DDD does not recommend approval, the applicant will be notified by the DOH-DDD. The applicant will be required to wait six months and receive provider training from the DOH-DDD prior to being able to submit a revised application.

b. Current Medicaid I/DD Waiver Providers

1) Providers requesting to add or change a residential or non-residential (Adult Day Health) setting where participants receive waiver services; or to deliver additional services to be included in their array of services must contact the DOH-DDD-CRB.

a) The DOH-DDD-CRB will inform the Provider if submission of a DOH-DDD Medicaid I/DD Waiver Application and/or other documentation will be required.

b) The Provider must demonstrate the capacity and qualified staff to deliver the additional services requested.

c) For changes that involve a new residential or non-residential (Adult Day Health) setting where the participants will receive waiver services, the Provider must notify the DOH-DDD of the new setting and the setting must demonstrate compliance with the HCBS final rule prior to approval.

d) For changes that involve adding an EVV service such as PAB, Chore, Respite or PDN, the Provider must demonstrate the plan to use an alternate EVV system that meets all federal and state requirements; or the plan to use the selected state-wide EVV system upon approval.

e) The Provider must demonstrate compliance with all requirements set forth in these Waiver Standards. If the Provider has an approved Corrective Action Plan (CAP) from the previous monitoring visit or special investigation, the Provider must demonstrate that the actions described in the CAP have been completed. A request to add a new service or setting will not be processed if the Provider has an outstanding CAP that has not been approved.

f) If utilization data determines that the Provider has not delivered an approved service for two (2) years or more from the approved date, then the Provider will be notified and the service may be removed from the Provider's approved array of services.

2) Providers requesting changes to current information, including but not limited to location, address, phone number and fax number, must complete the following:

a) Notify the DOH-DDD by email to doh.dddcrb@doh.hawaii.gov.

b) Update information in the Provider Portal.

c) Complete the change using the HOKU Provider Enrollment System at: https://medquest.hawaii.gov/en/plans-providers/become-a-medicaid-provider.html

3. Provider Agreement with the Department of Human Services (DHS)

Providers must have a current and valid written Provider Agreement on file with DHS-MQD and comply with all of the terms of the Provider Agreement and the Waiver Standards. The completed and executed Provider Agreement and any attachments constitute the full written agreement. The Provider Agreement is revalidated every five (5) years from the approval letter date. It is recommended that Providers start the revalidation process online using HOKU. Providers must use the DHS-MQD assigned

HOKU Application ID# related to the Medicaid Provider ID#. If a Provider does not know the assigned HOKU Application ID#, they shall email HCSBInquiries@dhs.hawaii.gov to request for it.

The Provider must maintain documentation of current insurance coverages:

a. general liability insurance in the amount of one million dollars ($1,000,000) per occurrence for bodily injury or property damage and two million dollars ($2,000,000) in aggregate;
b. professional liability, if applicable, in the amount of one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in aggregate;
c. automobile insurance, if applicable, in the amount of one million dollars ($1,000,000) per occurrence.

3.2 – GENERAL REQUIREMENTS FOR MEDICAID I/DD WAIVER PROVIDERS

A. Adherence with Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Provider must have an internal P&P that meet federal and state requirements on the following:

1. Confidentiality of individuals' records pursuant to HRS §333F-8 (a) (9); and 333E-6 and HIPAA. The Provider must comply with HIPAA.
2. As a "covered entity," the Provider must comply with all of the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions and code sets, and national employer and provider identifiers. See 45 CFR Parts 160, 162, and 164.
3. The Provider will be required to conduct annual HIPAA Privacy and Security trainings for all staff.

B. Compliance with Limited English Proficiency Requirements

The Provider is required to adhere to federal and state laws for limited English proficiency. All Medicaid I/DD Waiver Providers are covered entities under Hawai'i Revised Statues section 321C-2. Providers must provide interpreter services to assist a participant to access waiver services.

The State of Hawai'i State Procurement Office (SPO) offers a cooperative purchasing program with the State for organizations that qualify. This program enables organizations enrolled

through this program to obtain telephonic interpretation services at a government/discounted per-minute rate. The link to learn more about the cooperative purchasing program is at:

http://spo.hawaii.gov/for-vendors/non-profits/cooperative-purchasing-program/

C. Requests from State or Federal Agencies

The Provider must respond within specified timelines to all requests for information or action that come from DOH-DDD as the waiver operating agency, DHS-MQD as the State Medicaid agency, or CMS or its contractors as the federal Medicaid agency.

For example, DOH-DDD periodically sends surveys to the providers to determine workforce capacity. Another example is the Payment Error Rate Measurement (PERM) audit conducted by CMS and its contractor every three years.

D. CMS Home and Community Based Services (HCBS) Final Rule (79 FR 2947) on Community Integration (HCBS final rule)

The Provider must be in full compliance with the HCBS final rule settings requirements and maintain compliance on an ongoing basis. Providers delivering services prior to the previous Waiver renewal effective July 1, 2016, must use the transition period to complete Evidence Template(s) for each residential and non-residential setting and develop and implement remediation plans to reach full compliance by March 2023. Providers who do not demonstrate compliance will be required to complete a formal Corrective Action Plan (CAP) and may be subject to sanctions.

The transition period is not available for a new Provider applicant or an existing Provider seeking to add a new service or to add or change a residential or non-residential (Adult Day Health) setting where participants receive waiver services. Any new Provider or residential or non-residential (Adult Day Health) setting where participants receive waiver services approved after July 1, 2016 must be fully compliant with the HCBS final rule settings requirements prior to the approval and delivery of a waiver service.

As part of compliance with the HCBS final rule, any necessary restrictions, limitations or modifications of a participant's rights or freedoms must be considered through the person-centered planning process and incorporated in Individualized Service Plan (ISP), including documentation of:

1. a highly individualized approach,
2. positive interventions used prior to the modification,
3. less-intrusive methods that did not successfully meet the individual's assessed needs,
4. how the modification is directly proportionate to the specific assessed need,

5. regular data collection related to the effectiveness of the modification,
6. frequency of periodic reviews,
7. informed consent, and
8. an assurance the modification will not cause harm.

Controls on personal freedoms or rights cannot be imposed on a class or group of individuals. Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be implemented as "house rules" in any setting, regardless of the population served, and must not be used for the convenience of staff.

E. Electronic Visit Verification (EVV)

The Provider is required to use an EVV system when approved to deliver the following services:

- Chore
- Personal Assistance/Habilitation (PAB)
- Private Duty Nursing (PDN)
- Respite

Providers have the option to use the selected statewide EVV system or an alternate EVV system of their choice that meets all federal and state requirements. For more information on EVV visit: https://medquest.hawaii.gov/en/plans-providers/electronic-visit-verification.html.

F. Transition, Coordination, and Continuity of Care

Participants and Providers may experience changes and transitions at various times. When changes occur, the Provider must work with the participants, families, guardians, and Case Managers to support continuity and smooth transitions. Changes and transitions include but are not limited to the following:

1. A participant requests to transfer services from one Provider to another Provider.
   The Provider who currently delivers services and the Provider who will begin services must share information, upon request and with proper releases of information, to ensure a smooth transition. The CM will coordinate the transition.
2. A Provider initiates action to terminate services for any reason, such as requesting to remove a service from their array of services, not being able to provide services to a participant or group of participants or an area of the state, or ends all waiver services by closing the agency.

a) The Provider must give written notice to the CM and DOH-DDD-CRB of any termination of waiver services at least 30 calendar days prior to the change.
b) The Provider must coordinate with respective CMs and allow thirty (30) calendar days for CMs to transition their participants to alternative services chosen by participants, their families, and guardians if applicable.
c) DOH-DDD reserves the right to request additional time from the Provider beyond thirty (30) calendar days to ensure a smooth transition of participants to another provider or other services.

3. Provider capacity changes. The Provider must immediately notify the participant, family and guardian(s), if applicable, and CM if they do not have appropriate or available staff to deliver a service.
4. A participant chooses Medicaid-funded Consumer-Directed Option instead of Waiver Provider delivered services.

G. Emergency Preparedness

The Provider must have a current written Emergency Preparedness Plan (EPP) that addresses the agency's protocols for responding to natural or man-made disasters, technological or infrastructure failures, disease outbreaks or other types of emergencies.

When an emergency has been declared, Providers must report to DOH-DDD when their emergency preparedness action plan has been implemented and outline steps taken to ensure the safety of the participants and staff. Providers must respond to requests from DOH-DDD and provide updates on the status of participants who may need additional supports due to the event. DOH-DDD may request information through agency self-assessments, policies or other documentation that demonstrate health and safety of participants are fully addressed.

H. Compliance with DOH-DDD's Policies & Procedures (P&P)

The Provider must have written P&Ps that align with DOH-DDD P&Ps where applicable. The following P&Ps must be in accordance with DOH-DDD's P&Ps:

1. Positive Behavior Supports,
2. Restrictive Interventions, including Prohibited Restricted Interventions, and
3. Adverse Event Reporting.

In addition, Providers must have written P&Ps for:

1. emergency protocols,
2. alcohol and drug-free workplace,
3. protection of participant rights and
4. confidentiality of participant records.

3.3 – HEALTH AND WELFARE OF PARTICIPANTS

A. Adverse Event Reporting

The Provider must follow current procedures for Adverse Event Reporting. The Adverse Event Report form and instructions are in Appendix 5, 5C.

1. Types of Adverse Events

   The following types of adverse events require a verbal report and submission of a written report to the DOH-DDD CM:

   a. Suspected abuse and neglect, as referenced in HRS §350-1 for children and HRS §346-222 for adults, and financial exploitation as referenced in HRS §346-222 (see also DOH-DDD P&P #2.05, Mandatory Reporting of Abuse and Neglect, located in Appendix 5, 5A);
   b. Injuries of a known or unknown cause sustained by the participant requiring medical or dental treatment. Medical or dental treatment is defined as treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization;
   c. Medication errors and unexpected reactions to drugs or treatment. Medication errors includes wrong medication, wrong dose, wrong time, missed dose, wrong route/method, or failure to document or incorrect documentation;
   d. Change in the participant's behavior, including but not limited to aggression, self-injurious behaviors, property destruction, or sexualized behaviors that may require a new or updated BSP as a result of the intensity and/or severity of the behavior;
   e. Changes in the participant's health condition requiring medical or dental treatment or hospitalization. Medical or dental treatment is defined as treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization;
   f. Death of the participant regardless of cause or location of death;
   g. Participant's whereabouts unknown regardless of the amount of time the participant is missing or unaccounted for;
   h. Any use of restraints such as chemical, mechanical, or physical interventions used as a last resort on an emergency basis to protect the participant from imminent self-harm or

harm to others using the least restrictive intervention possible and for the shortest duration necessary;

i. Any use of seclusion in which a person is involuntarily confined in a room or area from which they are presented from having contact with others or leaving, by closing a door or using another barrier. Seclusion is prohibited and shall not be utilized with participants;

j. Any use of prohibited restrictive intervention or procedure (other than restraints and seclusion which shall be reported respectively) that restricts the participant's freedom of movement, access to other locations, property, individuals or rights.

2. Reporting and Remediation Requirements

The Provider must assure that all staff and licensed/certified caregivers are informed and adhere to the Policy and Procedures (P&P) for Adverse Event Reporting.

a. A verbal report of an adverse event must be provided to the DOH-DDD CM or the designee (on-duty CM, if applicable, or supervisor) within the next business day of an adverse event that occurred during a billable waiver service. If informed about an adverse event that occurred but was not during a billable waiver service, a verbal report must be provided within the next business day of the date informed. Refer to Table 3.3-1 for verbal timeline examples.

1) A verbal report consists of speaking to a DOH-DDD CM or the designee to verbally report what occurred, including details of the event, actions taken for the participant's immediate safety and other pertinent information.

2) If a message is left during non-work hours (i.e., evenings, weekends, and holidays), it is not considered a verbal report. A message may be left; however, a call to the DOH-DDD CM or the designee must be made on next business day to report the adverse event.

b. A written DOH Adverse Event Report form must be completed and submitted to the DOH-DDD CM within three (3) days or next business day if the 3rd day falls on a weekend or holiday of the adverse event. The written report must include immediate actions taken to safeguard the participant, and actions taken or will be taken to prevent the recurrence of the event, including timelines for implementation. If informed about an adverse event that occurred but did not happen during a billable waiver service, a written

report within three (3) days or next business day if the 3rd day falls on a weekend or holiday of the date informed. Refer to Table 3.3-2 for written timeline examples.

1) Written reports must be completed and submitted through the Provider Portal.
2) Hard copies will not be accepted.

c. For adverse events involving suspected abuse, neglect, or financial exploitation a report must be made to Child Welfare Services or Adult Protective Services within the next business day.

d. Information on the DOH Adverse Event Report form is accurate and complete. Any form that has missing, inconsistent, or incomplete information must be revised and re-submitted to the DOH-DDD CM within the next business day of the request. The DOH-DDD CM's assessment of the immediate action taken and plan of action to prevent the recurrence of the adverse event must be reviewed.

e. Implement and monitor the plan of action and make revisions as necessary, including additional actions recommended by the DOH-DDD CM to ensure the participant's health and safety.

TABLE 3.3-1: ADVERSE EVENT REPORTING: VERBAL TIMELINE EXAMPLES

Verbal Reporting Timelines (Next business day)	
Event Date	**Verbal Report to CM**
Monday	Tuesday
Friday	Monday (if Monday is a holiday, then Tuesday)

TABLE 3.3-2: ADVERSE EVENT REPORTING: WRITTEN TIMELINE EXAMPLES

Written Reporting Timelines (3 days or next business day if 3rd day is a weekend or holiday)	
Event Date	**Verbal Report to CM**
Monday	Thursday
Thursday	Monday (since the 3rd day falls on a Sunday)
Friday	Monday (if Monday is a holiday, then Tuesday)

Provider Safety Measures

The Provider must have necessary safeguards to protect the health and welfare of participants. In addition to the participant safeguards described in Section 1.7, the Provider must have procedures in place for ensuring the following requirements are met:

1. Participant health risk and safety considerations are assessed and potential interventions that promote health, independence, and safety with the informed involvement of the participants are identified.
2. Systematic safeguards are in place to protect participants from critical incidents and other life endangering situations.
3. Behavioral interventions are implemented according to approved behavioral support plans.
4. Medications are managed efficiently and appropriately in accordance with applicable State laws.
5. Safeguards are in place to protect and support participants in the event of natural disasters or other public emergencies.
6. Conduct internal investigations to respond to situations where serious health and safety issues are identified through the AER process or other methods, wherein immediate correction is required to avoid imminent harm to participants. The Provider will complete an internal investigation and specify actions to be taken to prevent the situation from occurring again. DOH-DDD may request a copy of the Provider's internal investigation and remediation activities. DOH-DDD may also make recommendations for remediation based on the results of the internal investigation or conduct a special monitoring review or investigation.

3.4 - STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS

Staff refers to employees of the Provider who provide direct service to participants, which includes licensed/certified caregivers who are employed by the Provider.

For the purposes of this document, licensed/certified caregiver refers only to caregivers who are licensed or certified by the State, deliver Residential Habilitation (ResHab) services and are not employed by the Provider.

The Provider will ensure that all staff and licensed/certified caregiver qualification requirements are met prior to providing services and remain current during service delivery. If any staff qualification requirements are not met, staff must work only under line of sight supervision and never be left unattended with a participant until all qualification requirements are met.

A. General Requisites

1. The Provider must assure that all staff:
    a. be at least 18 years of age;
    b. be able to work in the United States;
    c. have a high school diploma or General Equivalency Diploma (GED);
        1) for staff with neither, a high school diploma nor a GED, the Provider must supply written attestation that the staff meets the requirements for the position, including but not limited to the ability to understand and follow written and verbal instructions, complete written documentation, and perform the duties required for the position.
        2) This requirement applies to all staff providing direct waiver services who are hired on and after July 1, 2017. Staff hired prior to this date are exempt from this requirement and personnel records do not need to contain the diploma or GED or attestation.
    d. For any staff who graduated from a secondary education program where a high school diploma is a pre-requisite, such as an associate's degree or a bachelor's degree, DOH-DDD will accept the primary source verification from the university in lieu of the high school diploma or GED.
    e. have relevant education and/or work experience;
    f. maintain current Hawai‘i professional licenses, certificates, and liability insurance;

g. maintain a current valid driver's license in accordance with Hawai'i state law and access to a vehicle if required as part of the staff duties. The vehicle must have current motor vehicle registration, safety check, and insurance.

2. The Provider must maintain a copy of current licenses and certificates for each licensed/certified caregiver and have mechanisms in place for being notified of any change to the status of a caregiver's license or certificate.

B. Training Requirements

The Provider must be able to demonstrate that training is provided in accordance with State requirements and Waiver Standards.

1. Training and New Staff Orientation

   a. New Staff Orientation for all new staff must include the following 17 training topics. Providers may require and provide additional training topics.

      1) ***CMS Home and Community Based Services (HCBS) final rule (79 FR 2947) on community integration overview and implementation****

      2) ***Person Centered Planning****

      3) ***Positive Behavior Supports, Restrictive Interventions and Prohibited Restrictive Interventions****

      4) ***Adverse Event Reporting (AER)****

      5) ***Civil Rights****

      6) ***HIPAA Privacy and Security****

      7) Overview of Intellectual and Developmental Disabilities

      8) Orientation to Medicaid I/DD Medicaid Waiver Services

      9) Overview of ISP/IP Process

      10) Basic Health and Safety

      11) Preventing Abuse and Neglect

      12) Documentation

      13) Communication (Provider, family, participants, DOH-DDD staff)

      14) Job Responsibilities

      15) Ethical Conduct

      16) Emergency Preparedness

17) Participant Rights, Grievances and Responsibilities

Mandatory topics that all staff must be trained on annually

2. Continuing Education

   a. The Provider must conduct annual training for all staff on the six (6) mandatory topics listed below, which are also identified with the (*) in the New Staff Orientation training topics.
      1) CMS Home and Community Based Services (HCBS) final rule (79 FR 2947) on community integration overview and implementation*
      2) Person Centered Planning*
      3) Positive Behavior Supports, Restrictive Interventions and Prohibited Restrictive Interventions*
      4) Adverse Event Reporting (AER)*
      5) Civil Rights*
      6) HIPAA Privacy and Security*
   b. In addition to the mandatory topics, DOH-DDD requires that all staff receive at a minimum, training on two additional topics from the New Staff Orientation training topics list on an annual basis.
   c. All changes related to State and agency policies affecting the operations of the Medicaid I/DD Waiver, e.g. new forms or procedures, must be included as part of continuing educations.

C. General Staff and Licensed/Certified Caregiver Qualifications

1. Table 3.4-1 describes general staff qualifications and requirements.
   a. Training for first aid and Cardiopulmonary Resuscitation (CPR) may be completed face-to-face or on-line.
   b. First Aid training requirement may be waived for licensed nurses.
   c. TB Clearance includes testing or screening in accordance with HAR 164.2.
   d. Staff who are family members of participants must meet all requirements including TB screening, first aid training and CPR training.
   e. Table 3.4-1 does not include licensed/certified caregivers. Licensed/certified caregivers must adhere to their license or certification rules and be in good standing with the

respective licensure or certification agency.

2. Table 3.4-2 describes the frequency of criminal history record checks and registry screen (see Appendix 7B, Hyperlinks to Resources for Required Clearances).
   a. A Statement of Authenticity is only required for State Name Check eCrim results when the Provider requests an exemption from the Criminal History Record and Background Check Standards.
   b. DOH-DDD requires the decision from the request for exemption, but if the decision is pending, Providers must maintain a copy of the exemption forms that were submitted, which would include the Statement of Authenticity.

3. Additional provider qualifications are required for some waiver services to reflect the specialized skills required to deliver the service. Additional service-specific qualifications are included in Section 4 of the Waiver Standards.

4. If any outstanding staff requirement documentation and clearances are identified during the DOH-DDD Provider validation process, the identified staff must work only under line of sight supervision and never be left unattended with a participant until the necessary documentation and clearances are obtained and accepted by DOH-DDD.

D. Additional Qualifications for Service Supervisors

1. All Service Supervisors must meet the additional minimum qualifications as follows:
   a. possess a bachelor's degree from an accredited college or university in social sciences or education; or
   b. possess a bachelor's degree from an accredited college or university in another field with one (1) year verifiable experience working directly with individuals with disabilities or the elderly; or
   c. be a Registered Nurse licensed in the State of Hawai‘i.

2. If the Service Supervisor possesses qualifications from foreign colleges or universities, which are accredited, the following requirements must be met:

a. The Provider must document verification of accreditation from foreign colleges and universities that the degree is equivalent to or higher than a bachelor's degree in the United States; or
b. The Provider must document the staff's acceptance of admission to a graduate program at the University of Hawai‘i, Hawai‘i Pacific University, or Chaminade College as acceptable criteria to meet staff qualification.

3. Additional service-specific supervision standards must also be met and are included in Section 4 of the Waiver Standards.

TABLE 3.4-1: General Staff Qualifications and Requirements

Clearance	A - Service Supervisor	B - Direct Support Worker – Agency (DSW)	C - Employment Specialist	D - Direct Support Worker – Consumer-Directed Services (DSW-CD)	E - Registered Nurse – RN (applies whether RN is Svc Sup or providing direct Nursing services)	F - Licensed Practical Nurse - LPN	G - Training & Consultation Licensed Professional or qualified designee	H - Vendor, Contractor, Transpor-tation Provider
Orientation upon hire	Yes	Yes	Yes	N/A	Yes	Yes	Waived	N/A
Annual Training	Yes	Yes	Yes	N/A	Yes	Yes	Waived	N/A
TB clearance	Yes	Yes	Yes	N/A	Yes	Yes	Yes	N/A
First Aid	Yes	Yes	Yes	N/A	Waived	Waived	Waived	N/A
CPR	Yes	Yes	Yes	N/A	Yes	Yes	Waived	N/A
Criminal History Check	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A
Fingerprinting	Yes	Yes	Yes	Waived	Yes	Yes	Yes	N/A
Adult Protective Services clearance	Yes	Yes	Yes	Waived	Yes	Yes	Yes	N/A
Child Abuse and Neglect Registry Clearance	Yes	Yes	Yes	Waived	Yes	Yes	Yes	N/A
Both: Med-QUEST and OIG Lists of Excluded Individuals/ Entities	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Clearance	A - Service Supervisor	B - Direct Support Worker – Agency (DSW)	C - Employment Specialist	D - Direct Support Worker – Consumer-Directed Services (DSW-CD)	E - Registered Nurse – RN (applies whether RN is Svc Sup or providing direct Nursing services)	F - Licensed Practical Nurse - LPN	G - Training & Consultation Licensed Professional or qualified designee	H - Vendor, Contractor, Transpor-tation Provider
Bachelor's Degree	Yes	No	No (Bachelor's Degree if also the Service Supervisor)	No	X (Associates Degree or certificate accepted with valid license)	No	Refer to waiver service for specific qualification requirements	N/A
RN license	N/A	N/A	N/A	N/A	Yes	N/A	Refer to waiver service for specific qualification requirements.	N/A
LPN license	N/A	N/A	N/A	N/A	N/A	Yes	Refer to waiver service for specific qualification requirements	N/A
Trained in implementation of ISP and IP if applicable	Yes	Yes	Yes	Yes	Yes	Yes	Waived	Waived
Continuing education	Mandatory annual topics	Mandatory annual topics + 2 additional topics	Mandatory annual topics	Waived	Mandatory annual topics	Mandatory annual topics	Continuing education in accordance with licensure requirements	N/A

NOTE: This table does not include licensed/certified caregivers. Licensed/certified caregivers must provide a copy of their current license or certificate to be maintained in the Provider file. The caregiver must be in good standing with the respective

licensure or certification agency. The Provider must have a mechanism in place to be notified by the caregiver of any change to the status of their license or certificate.

E. List of Excluded Individuals/Entities

1. In accordance with federal law (Sections 1128 and 1156 of the Social Security Act) the U.S. Office of the Inspector General (OIG) is given the authority to exclude individuals and entities from federal health care programs like Medicaid. Excluded individuals are prohibited from furnishing all types of services including administrative and management services.

    a. OIG maintains a list called the List of Excluded Individuals and Entities (LEIE) and the LEIE must be checked prior to hiring/contracting with an individual or entity, as well as annually for every employee and contractor.
    b. The LEIE is updated monthly and is located at https://oig.hhs.gov/exclusions/exclusions_list.asp
2. Med-QUEST requires that "any provider participating or applying to participate in the Medicaid program **must search Hawai'i's excluded provider list monthly and the List of Excluded Individuals and Entities (LEIE) on an annual basis** to determine if any existing employee or contractor has been excluded from participation in the Medicaid program. In addition, any provider participating or applying to participate in the Medicaid program must search both lists prior to hiring staff to ensure that any potential employees or contractors have not been excluded from participating in the Medicaid program."

    a. Med-QUEST maintains a list that must be checked monthly.
    b. The list is titled "Excluded Individuals".

TABLE 3.4-2: FREQUENCY FOR THE REQUIRED CLEARANCES

Clearance	Upon Hire	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
FBI and State Fingerprint (AFIS) (Fieldprint)	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A
State Name Check e-Crim (HCJDC)	N/A	N/A	N/A	Yes	N/A	Yes	N/A	Yes	N/A
APS/CAN (Fieldprint)	Yes	Yes	N/A	Yes	N/A	Yes	N/A	Yes	N/A
LEIE (List of Excluded Individuals/ Entities)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Example:

a. DSW hired on 1/15/2017 Upon hire, the employee will submit the first FBI and State fingerprinting (Fieldprint) and APS/CAN (Fieldprint). A "greenlight" must be received prior to delivering any direct services. The Provider must also check the Med-QUEST excluded list and the OIG List of Excluded Individuals/Entities (LEIE).
b. On 1/15/2018 (year 1), the employee will submit the second FBI and State fingerprinting (Fieldprint) and APS/CAN (Fieldprint). A "greenlight" must be received to continue to provide services. Once the second fingerprinting is submitted, the DSW is not required to submit another fingerprinting. **From this time forward, APS/CAN will be required every other year**. The next time the APS/CAN clearances are required is on 1/15/2021 (year 3). The LEIE must be checked annually.
c. On 1/15/2019 (year 2) - Must check LEIE.
d. On 1/15/2020 (year 3) - APS/CAN clearances and Certified e-Crim required, must check LEIE.
e. On 1/15/2021 (year 4) - Must check LEIE.
f. On 1/15/2022 (year 5) - APS/CAN clearances and Certified e-Crim required, must check LEIE.

F. Exceptions to Provider Qualifications Process

1. In the rare situation where a Provider requests an exception to the general and/or additional service-specific provider qualifications, the Provider must submit a written request with justification to DOH-DDD-CRB (see Appendix 3, Assistance Directory, for DOH-DDD-CRB address.)
2. If additional information is required to make the decision for an exception, the Provider must submit all documentation within fifteen (15) business days.
3. DOH-DDD will review the request and make a decision, which will be issued to the Provider in writing within fifteen (15) business days once all documentation has been received from the Provider.

G. Maintenance of Staff and Licensed/Certified Caregiver Records

The Provider is required to maintain a file for all staff and licensed/certified caregivers who provide direct services to participants. The file must be maintained in an organized manner; be readily available for monitoring and/or review; and include, at a minimum, current job descriptions, documentation of qualifications, employment and contractual requirements, as applicable, and documentation of current license or certification.

3.5 - PROGRAMMATIC REQUIREMENTS

A. Individual Plan Development and Updates

The Provider must ensure an Individual Plan (IP) is developed based on the participant's Individualized Service Plan (ISP) and aligned with the participant's needs, preferences, personal goals, and abilities, within thirty (30) calendar days of the ISP meeting and prior to implementation.

1. The IP must include the following minimum requirements:
    a. The participant's goals, objectives, outcomes for each waiver service identified in the ISP.
    b. Detailed strategies to support the participant's achievement of each outcome for each waiver service.
    c. Strategies, protocols and/or supports to address identified risks and safety concerns.
2. The Provider must assure:

a. The participant, members of their circle of support and CM are included in the development of the IP and any revisions.
b. Participants have the authority and are supported to direct and manage their own service(s) to the extent they wish.
c. The IP is completed and written in measurable terms easily understood by the participant, primary caregiver(s) and/or worker(s) required to implement the IP.
d. Procedures are in place to revise IP(s), as applicable, to address significant changes in the participant's needs or circumstances; for example if there is a change in health status, increased frequency of behaviors or an outcome is achieved.
e. The IP and any revisions are approved and signed by the participant and/or legal guardian.
f. The participant or the participant's legal or designated representative and the DOH-DDD CM receive copies of the IP within seven (7) business days of the completion of the IP or any subsequent revisions; and the distribution is documented.
g. Staff and licensed/certified caregivers required to implement the IP(s) possess the requisite skills, competencies and qualifications to support the participant effectively.
    - Staff training on the implementation of the IP is documented.
h. Each service is delivered in accordance with the IP, including type, scope, amount, duration, and frequency specified in the IP.

B. Reports to Case Manager

The Provider will review and report participant outcomes for each waiver service quarterly or more frequently as identified in the Waiver Standards or ISP.

The following services are for an episode or ongoing technology supports and are excluded from the quarterly reporting requirement: Assistive Technology, Personal Emergency Response System, Specialized Equipment and Supplies, Environmental Accessibility Adaptations, Vehicular Modifications, and Non-Medical Transportation.

1. The reports will summarize the status of progress toward each outcome for each waiver service and include, at a minimum:

    a. description of the strategies that were implemented during the reporting period;
    b. assessment of the effectiveness of the strategies implemented;

c. evaluation of the participant's progress or lack of progress in the achievement of desired outcomes, including behavioral challenges and any significant events that may have had an impact;
d. recommendations and plans for revisions or improvements, if necessary; and
e. participant satisfaction of services.

2. The Provider shall distribute reports according to the following requirements:
   a. Provide copies of the reports to the CM quarterly or more frequently as identified in the Waiver Standards or ISP.
   b. Assure reports are completed and distributed within 30 calendar days after the end of the quarter or frequency identified in the Waiver Standards or ISP (for example, quarter ends on December 31, report is due by January 30).
   c. Document the distribution of reports including the date, the mode of distribution (fax, mail, and hand-delivery) and recipients.
   d. Provide copies of the reports to the participant and the participant's legal or designated representative as requested.

C. Oversight and Monitoring Responsibilities

The Provider is responsible for the staff's development to perform the work required and learn new skills, improve skills and problem-solve to best support the participant to achieve his/her vision of a good life.

1. Oversight and monitoring practices include, but are not limited to, the Service Supervisor:
   a. ensuring that the needs of each participant are matched with a staff who has received training in the services to be provided to the participant and is knowledgeable about the needs and preferences of the participant;
   b. coaching, modeling, teaching, demonstrating, and watching the staff perform return demonstrations of implementation of IP strategies before the worker starts with the participant and on an ongoing basis;
   c. ensuring that the place where the service is delivered is suitable to the activity and can physically accommodate the participant in a safe, comfortable manner, and that the participant's privacy and preferences are known to staff and are respected;

d. performing face-to-face observations/reviews of services being delivered to participants, assessing the quality of the implementation of IP strategies and activities and evaluation of the participant's response and progress.

1) Providers are strongly encouraged to implement oversight and monitoring to ensure alignment with best practice which includes meeting face-to-face with each worker implementing the IP monthly; and varying the visits to observe service delivery at different times during the participant's scheduled hours, on weekdays, night-time, and weekends. For example: If a participant has PAB services in the family home in the morning and in the evening, the Service Supervisor should alternate observing morning and evening activities.

2. Face-to-face observations/reviews of services being delivered to participants shall be at the frequency specified in the ISP or if not specified, at least monthly. Reviews may be in-person or by a technology-based alternative format, such as HIPAA-secure video conferencing, if appropriate and as indicated in the ISP. Prior to using an alternative format for oversight and monitoring of staff, the Provider must demonstrate compliance through written assurances that services observed/reviewed via telehealth comply with HIPAA and a non-public facing, HIPAA-compliant platform will be used. The Provider must submit written assurances for review by the DOH-DDD compliance officer.

a. The standard is the Service Supervisor observes/reviews each waiver service at least once per month, unless otherwise specified.

1) For participants receiving both ADH and CLS-G services from the same provider, these services are a "group" such that the observations may be alternated monthly between which service is observed directly, i.e., Service Supervisors are not required to complete a monthly observation for both services. This also applies if the participant is approved for 1:1 services in the ADH and CLS-Ind rather than the typical authorization of ADH and CLS-G. For example, the Service Supervisor schedules the visit to observe ADH on the even-number months (February, April, etc.) and the visit to observe CLS-G on the odd-number months (January, March, etc.) during the plan year.

2) For participants receiving both PAB and CLS-Ind services from the same provider, these services are a "group" such that the observations may be alternated monthly

between which service is observed directly, i.e., Service Supervisors are not required to complete a monthly observation for both services. For example, the service supervisor may schedule the visit to observe CLS-I on the even-number months (February, April, etc.) and the visit to observe PAB on the odd-number months (January, March, etc.) during the plan year.

3) If the circle determines at the ISP that there are exceptional circumstances, the ISP can specify a frequency for face-to-face observation visits to occur every other month (six visits per year) or once per quarter (four visits per year). Exceptional circumstances are limited to rural locations where travel distance and/or time require the service supervisor to travel to another island or have a typical drive time of 1.5 hours or more each way to reach the participant and staff. Exceptional circumstances are not permitted for:
    a) ADH and CLS-G by the same provider – alternating months for the "group" of services is required. This also applies if the participant is approved for 1:1 services in the ADH and/or CLS-Ind rather than the typical authorization of ADH and CLS-G.
    b) Residential Habilitation – monthly or more frequent visits are required.
    c) Extended drive times due to traffic-related delays, construction, or accidents.

b. Face-to-face observation/review visits must include the following activities:
    1) assessment of the quality of service implementation and activities as specified in the IP, with focus on how the staff or licensed/certified caregiver implements the strategies and activities to reach outcomes;
    2) evaluation of the participant's response and progress toward achieving outcomes;
    3) coaching, modeling, teaching, and demonstrating for the staff, if applicable;
    4) identification of barriers to services and achieving outcomes including recommendations for IP interventions and/or discussions with the CM and circle of support for IP revisions, as necessary.
c. Face-to-face observations/reviews must be documented for each visit and include, at a minimum, Service Supervisor notes on the activities listed above, person(s) present during the visit, the date, duration and location of the visit or alternate format observation.

D. Maintenance of Participant Records

The Provider must maintain confidential records for each participant. The individual records must include but is not limited to the following:

1. Emergency and personal identification information including, but not limited to, the following:

    a. participant's address, telephone number;
    b. names and telephone numbers of the family, licensed or certified care provider, relative, designated representative and/or guardian;
    c. physician's name(s) and telephone number(s);
    d. pharmacy name, address and telephone number if necessary to assure participant health and safety;
    e. health plan information;
    f. medical information, which must include, but is not limited to:
        1) medical orders as applicable for waiver services;
        2) precautions for participation in an activity;
        3) diagnoses or conditions;
        4) infections, contagious or communicable conditions;
        5) current medications;
        6) known allergies including food allergies;
        7) special health care needs such as aspiration precautions, fall precautions, and high risk for skin breakdown; and
        8) special nutritional needs, to include the specific diet order or limitations.
    g. crisis contingency plan, if one is necessary, for the participant;
2. Programmatic information including, but not limited to, the following:
    a. participant's ISP and IP(s);
    b. BSP, if one is necessary, for the participant;
    c. documentation that the participant and/or family/guardian acknowledges that he/she has been informed of the participant's rights, responsibilities, and grievance procedures;
    d. reports (quarterly or more frequent);
    e. documentation of face-to-face observations/reviews of service delivery;

f. service delivery documentation, records and reports that include, at a minimum, the following:
   1) date, time (in and out), duration, and location of service delivery;
   2) documentation of activities or type of service rendered during service delivery: progress notes, contact logs, attendance, medication administration records (MARs) and other service delivery documentation;
   3) data collected that measures participant's progress in relation to the participant's IP, if applicable;
   4) documentation that minimum staffing ratios are maintained, when applicable;
   5) name of worker(s) providing services; and
   6) date, time, location, name and title of staff conducting the required face-to-face observations/reviews of services and/or telephone contacts.

3. The participant record is a legal document that must be kept in detail to permit effective professional review and provide information for necessary follow-up and care.
   a. Individual participant records must be kept in a manner that ensures legibility, order, timely signing and dating of each entry in black or blue ink.
   a. Documentation of verbal or written reports and follow-up, as necessary, received from other agencies, the participant's family, the participant's legal, designated representative, or caregiver must be reviewed to determine whether action needs to be taken by the Provider.

3.6 - BILLING AND CLAIMS PROCESSING

A. Billing for Claims

1. The Provider must follow the Medicaid claims billing process for fee-for-service providers per Medicaid Provider Manual Chapter 04 Claims Payments.
2. The Provider must bill claims to the DHS Fiscal Agent. Refer to Appendix 3, Assistance Directory, for contact information. Payment for services is based on compliance with billing protocols. Completed supporting documentation is required as proof of delivery of services.
3. Billing for Services with 15-minute Units:

One 15-minute unit is 8 or more minutes. To determine the number of units to bill, the Provider must aggregate the total time for the day and then round to the nearest number of 15-minute units. For example:

a. If a participant's day starts at 9:52 AM and ends at 10:53 AM, the Provider delivered 61 minutes of service and would bill for four (4) units.
b. If a participant receives services from 9:00 AM to 9:25 AM (25 minutes) and then from 3:00 PM to 3:25 PM (25 minutes) on the same day, the aggregate total would be 50 minutes, which would be rounded to three (3) units.

4. Billing for services subject to Electronic Visit Verification (EVV) requirements:
   a. Services subject to EVV requirements include PAB, Chore, Respite and PDN.
   b. Prior to billing the Provider must ensure that the units on the claim, for services subject to EVV, are supported by an electronic visit that has been verified in the selected state-wide EVV system.
      - The start and end of each visit should accurately reflect actual service delivery time according to the ISP. The state-wide EVV system will automatically round up to the next billable unit if staff log in and/or out of the EVV visit greater than seven (7) minutes before and/or after the start/end of the visit.
   c. Claims for services subject to EVV will be processed against the verified visits in the selected state-wide EVV system and will not be paid if there is not verified visit data to support the claim.
      More information can be found at:
      https://medquest.hawaii.gov/en/plans-providers/electronic-visit-verification.html

B. Claims Submission

1. Prior Written Authorization Required

   a. Medicaid waiver services authorized by the CM will be identified and documented in the ISP. The Provider must receive a prior authorization notice before the delivery of services. The lack of a prior authorization may result in a denied claim for payment.
   b. The prior authorization specifies the covered period of time in which to deliver services. Authorizations for many services will be annual, rather than monthly. When a direct

support worker's shift will cover two authorization periods (the shift will start on the last day of the annual authorization and will carry over into the first day of the new annual authorization), the Provider must submit two claims. For example:

The participant's ISP plan year authorized PAB services to start on July 15, 2018 and end on July 14, 2019. A new ISP was held in early July 2019 and a new ISP plan year authorization starts on July 15, 2019.The DSW provides PAB starting at 8:00 PM on June 14, 2019 until 2:00 AM on June 15, 2019. The Provider will submit Claim #1 for the hours worked between 8:00 PM and 11:59 PM for a total of 16 units. The Provider will submit Claim #2 for the hours worked between 12:00 AM and 2:00 AM for a total of eight (8) units.

c. The Provider must follow-up with the CM if a prior authorization has not been received and the service is identified in the ISP.
d. Prior authorization numbers are not required to be entered on the claim. However, the system will edit for a prior authorization. Any claim for service without a prior authorization will be denied.
e. If the participant has chosen to change providers at any point during the authorization period, the Provider that is ending services must update the CM in writing within 14 calendar days on the total number of units used during the authorization period. If the Provider does not update the CM within 14 calendar days, the CM will pro-rate the authorization in the calculator.

2. Cost Share

   If the cost share has been assigned to a Provider, the Provider must deduct the cost share amount from the claim.

3. Hard Copy Claims

   Providers may submit either hard copy or electronic claims to the DHS Fiscal Agent. The following must be adhered to for submitting hard copy claims:

   a. The claim must be filed on a standard CMS 1500 form and within the existing claim line limitation,
   b. All required fields must be completed, and
   c. The form must be signed.

4. Electronic Submission of Claims

   All claims submitted electronically must be submitted via a secure system that is tested and certified to be HIPAA compliant. Providers desiring to electronically submit HIPAA compliant claims should request an Electronic Claims Manual from the DHS Fiscal Agent. Alternatively, Providers may use the DHS Fiscal Agent's free software WinASAP to submit claims.

   In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative standards, any health care provider that completes electronic transactions is a covered entity that must use a National Provider Identifier (NPI) number on all transactions, such as claims for payment of waiver services. A transaction is defined as "an electronic exchange of information between two parties to carry out financial or administrative activities related to health care." MQD has been informed through the recent Payment Error Rate Measurement (PERM) audit that I/DD Waiver Providers must include NPI numbers on electronic claims submissions to meet federal requirements. MQD will be modifying the Provider Manual and I/DD Waiver Providers will no longer be classified as "atypical providers" that previously were not required to include NPI numbers.

   Although I/DD Waiver Providers are not currently mandated to include NPI numbers on claims submissions, Providers are advised to begin preparing for this requirement and watch for updates from MQD when the change becomes effective.

   If a Provider agency is unsure whether it is a covered entity as a health care provider, CMS has a simple tool to use. The website for this tool is Covered Entity Guidance Tool.

C. Timely Submission of Claims

All claims for payment of services must be submitted within 12 months following the date the service was rendered (42 C.F.R. §447.45). Any claims beyond the 12-month filing period must be submitted with a waiver of filing deadline in accordance with the Medicaid Provider Manual Chapter 04 Claims Payments. DHS-MQD will only consider situations with extenuating circumstances to waive the filing deadline. Extenuating circumstances include the following:

1. claims from third party,
2. court order, or
3. administrative hearing decision.

D. Claims Adjustment

Providers may file a claims adjustment or void previous claims:

1. Most adjustments and voids are to correct errors (procedure codes, participant I.D., dates, etc.) on previous claims.
2. Providers may also resubmit a denied claim.
3. Send hard copy adjustments to the DHS Fiscal Agent. For electronic filing, follow required procedures for adjusting or voiding a claim.

E. Pricing and Payment

All Medicaid waiver services are paid on an established rate schedule approved by CMS and DHS-MQD.

The Medicaid waiver payments are considered payment in full. No other costs can be billed to the participant or family except for Cost Share.

F. Editing Process

The claims system edits the claim in one process.

If the claim fails an edit or an audit, an error record is created. All failed claims are found in the Denied Claims section of the Remittance Advice. A description of the edit code is listed on the Processing Notes page of the Remittance Advice. Refer to the Hawai‘i Medicaid Provider Manual Chapter 04 for information on the Remittance Advice.

G. Overpayments and Recoveries

Overpayments are recovered by DOH-DDD for Medicaid waiver services through the DHS fiscal agent.

1. Overpayments discovered by the Provider must be reported immediately to DOH-DDD.
2. If an overpayment is identified in a post payment review, the Provider will receive notification of the reason for the overpayment, the amount of the overpayment, and the action to be taken by DOH-DDD.
3. DOH-DDD reserves the right to adjust future claims for the overpayment or demand a refund from the Provider within 60 days.
4. If submitting a refund to DOH-DDD for services, the Provider should contact the DHS Fiscal Agent for instructions.

H. Fiscal Appeals

Upon receiving notice of the denial of a written request to submit a claim, the Provider can request a Fair Hearing from DHS in accordance with Title 11, Chapter 1, HAR.

Upon receiving notice of an overpayment, the Provider may choose to submit a written appeal request within 30 days from the date of the notification letter in accordance with HAR §17-1736-33. The following should be included with the written appeal:

1. All documents including the relevant Individualized Service Plan (ISP) and timesheets; and
2. Other written evidence that the Provider would like considered at the hearing.

Providers should submit written appeal requests, along with all documents to:

Administrative Appeals Office
Department of Human Services
P.O. Box 339
Honolulu, Hawai‘i 96809

I. Remittance Advices

Each Remittance Advice is divided into five sections: 1) paid claims, 2) adjusted claims, 3) denied claims, 4) voided claims, and 5) claims in process. The last page of the Remittance Advice includes processing notes. Refer to the Hawai‘i Medicaid Provider Manual for a listing of the codes.

J. Payment Schedule

1. Checks are generally mailed one week after processing the claim.
2. Providers may also choose to receive payment via electronic funds transfer (EFT). Contact the DHS Fiscal Agent for information on establishing EFT.
3. For any checks that are considered stale (dated beyond 180 days of check date) or lost, the Provider should contact the DHS Fiscal Agent for instructions for re-issue.

3.7 - FISCAL ACCOUNTABILITY

CMS requires the State to complete a post payment review as part of waiver requirements to ensure financial accountability. Financial accountability is one of the six (6) mandatory assurances that the State must demonstrate compliance. This is achieved through ongoing fiscal

audit activities and regular reporting to CMS. The DOH-DDD Fiscal Section performs an annual fiscal audit on all Providers as part of the activities to meet this assurance.

Each Provider must prepare all supporting documentation required by the DOH-DDD Fiscal Section and participate in the annual fiscal audit. Since the Provider's services must be authorized and in alignment with the ISP, it is also the Provider's responsibility to obtain an approved ISP to file a claim.

A. Documentation Requirements for All Billable Claims

1. ISP – The Provider must have an approved ISP which covers the entire fiscal audit period. If an ISP ends in the middle of the audit period, more than one ISP may be needed. For example, if the audit period includes the months of March, April, and May, the ISP ending in March and the ISP starting in April will be required.

2. Participant Attendance Log – The Provider must have a participant's attendance log to substantiate the billed claims. Each participant's attendance log must contain the following:
   a. participant name;
   b. date(s) of service provided;
   c. time of service provided (both start time and end time are required);
   d. type and level of service, (such as ADH Tier 1);
   e. staff to participant ratio;
   f. name and signature of direct support worker delivering the service and information listed above; and
   g. name and signature of service supervisor verifying the service and information listed above.

3. DDD Fiscal Section may request additional documents that are not listed above and/or beyond the fiscal audit period to complete the fiscal audit.

Date and time stamp is required for all physical records signed by the Service Supervisor. An electronic signature with electronic date and time stamps of the entry is required for all electronic records.

B. Fiscal Audit

The fiscal audit follows the steps listed below. Each step in the process is described in detail below the list.

1. Pre-Audit
2. Audit
3. Audit Results
4. Post-Audit Actions
5. Informal appeal (and renumber everything after this)
6. Formal Appeal Request
7. DDD Training for Providers
8. Provider Corrective Actions
9. Follow-up Audit

1. Pre-Audit

   The DDD Fiscal Section will send an Audit Notification letter to the Provider thirty (30) calendar days prior to the scheduled audit date. The letter specifies whether the audit will be done on-site or by desk audit. A fiscal audit checklist will be included to assist the Provider with organizing the required documentation. The Provider will send the name and telephone number of a contact person for the audit, as well as a secured email address to the DDD Fiscal Section prior to the audit date. On the day of the audit, the DDD Fiscal Section will send an encrypted email with the names of the participants whose records are being audited to the Provider's designated contact person.

2. Audit

   Each Provider must be audited annually. The DDD Fiscal Section may perform additional audits during the year if needed. DDD will determine whether the audits will be completed on-site or by desk audits.

   The audit period consists of three (3) consecutive months. The period to be reviewed starts six (6) months prior to the month the audit is conducted. For example:

   Audit date: 8/1/2020 Audit period: 2/1/2020 – 4/30/2020
   Audit date: 1/15/2021 Audit period: 7/1/2020 – 9/30/2020

   a. General requirements:

The DDD Fiscal Section will contact the provider on the morning of the scheduled audit date via telephone to confirm the contact person is ready to receive the audit list of participants. The DDD Fiscal Section will then email the names of the participants whose records will be audited to the Provider's contact person of the audit.

b. On-site audit:

1) DDD Fiscal will arrive at the provider agency's site no later than the time indicated on the audit notification letter on the scheduled audit date. The fiscal audit list is provided to the provider agency via secured e-mail before the auditors arrive.
2) Provider agency is required to produce a copy of the required documents listed in 3.7-A for the auditor to perform an on-site fiscal audit.
3) Provider agency has until 3:00 pm on the same day to submit the requested documents. All documents submitted after 3:00 pm are considered late and will not be considered towards the initial audit.

c. Desk audit:

1) DDD Fiscal Office will contact the provider agency in the morning on the scheduled audit date via telephone to confirm provider's e-mail and the name of the contact person.
2) DDD Fiscal Office will send a fiscal audit list to the provider agency via secured email by the time indicated on the audit notification letter on the scheduled audit date.
3) Provider agency is required to submit a copy of the required documents listed in 3.7-A via encrypted e-mail, mail, or fax to DDD Fiscal Office by 3:00 pm if emailed or faxed.
4) Mail with a postmarked date after the audit date is considered late.
5) DDD Fiscal Office contacts the provider agency via telephone after 3:00 pm on the fiscal audit date to confirm the number of pages received via fax.
6) Late submissions will not be considered towards the initial audit.

3. Audit Results

Based on the documentation submitted by the Provider on the audit date, the DDD Fiscal Section will determine a compliance score (percentage) and a compliance rating.

a. Fiscal audit result of 100% is considered Fully Compliant.
b. Fiscal audit result of 86% to less than 100% is considered Substantially Compliant.
c. Fiscal audit result below 86% is considered Not Compliant.

4. Post Audit Actions

The Provider will receive an audit report and a letter indicating the Provider's compliance rating. If funds are to be recouped, a recoupment notification letter will be sent within thirty (30) calendar days of the audit.

a. Fully Compliant – The Provider receives an audit report and a fully compliant letter.
b. Substantially Compliant – The Provider receives an audit report, a substantially compliant letter, and a recoupment notification letter.
c. Not Compliant – The Provider receives an audit report, a non-compliant letter, and a recoupment notification letter. The Provider will be required to develop a Corrective Action Plan.

5. Informal Appeal Request

A Provider with an audit result below 100% will have an option to submit an applicable ISP(s) or participant attendance log(s) that was not provided on the audit date by requesting an informal appeal.

a. The request for an informal appeal must be submitted in writing within fourteen (14) calendar days from the date indicated on the initial audit report to:

Department of Health
Developmental Disabilities Division, Fiscal Section
3627 Kilauea Avenue, Room 104
Honolulu, Hawaii 96816

b. The Provider must submit additional ISP(s) and participant attendance log(s) along with a written request for an informal appeal to substantiate the claim. (See Documentation Requirements for all billable claims.)
c. A request for an informal appeal received after fourteen (14) calendar days from the date indicated on the audit report will not be accepted.

d. If a written request for an informal appeal and applicable ISP(s) or participant attendance log(s) are not submitted within fourteen (14) calendar days from the date indicated on the audit report, a recoupment letter will be initiated.
e. If the additional ISP(s) or participant attendance log(s) are determined by the DDD Fiscal Section to meet the requirements, the Provider will receive a written response to the informal appeal, adjust audit report, and an adjusted recoupment notification letter. The initial audit score and compliance rating remains the same.
f. If the additional ISP(s) or participant attendance log(s) are determined by the DDD Fiscal Section as not meeting the requirements, the Provider will receive a written review of the informal appeal letter and a recoupment letter.

6. Formal Appeal Request

Formal appeals are conducted by the Department of Human Services and the Provider has the right to appeal audit findings in accordance with the procedural requirements of chapter 17-1736, subchapter 3, of the Hawaii Administrative Rules. [Eff 09/01/03] (Auth: HRS §346-59; 42 U.S.C. § 1396a) (Imp: 42 C.F.R. §447.252).

a. The Provider may submit a request for a formal appeal in writing within thirty (30) calendar days from the date indicated on a review of informal appeal letter to:

Administrative Appeals Office
Department of Human Services
P.O. Box 339
Honolulu, Hawaii 96809

b. Based on the formal appeal decision, the Provider may receive a final recoupment letter if the recoupment amount is adjusted.

7. Provider Training

The DDD Fiscal Section will provide a training video for Providers regarding the documentation requirements. Providers with a Not Compliant audit rating below 86% must review the training video.

a. A pre-recorded training video will be made available to all Providers.
b. Technical assistance for individual providers upon request.

8. Corrective Action Plan (CAP)

   Providers with a Not Compliant audit rating below 86% must submit a Corrective Action Plan (CAP) to the DDD Fiscal Section within fourteen (14) calendar days from the date indicated on the latest recoupment notification letter. The purpose of a CAP is to assist the Provider to meet necessary document requirements indicated in 3.7-A.

   a. Corrective Action Plan (CAP) must:
      1) identify issues that need to be addressed.
      2) develop specific actions and timelines for a provider agency to implement.
      3) identify positions, if applicable, responsible for implementation.

   b. Providers that do not submit a Corrective Action Plan (CAP) within fourteen (14) calendar days from the date indicated on the recoupment notification letter may be subject to additional actions.

9. Follow-up Audit

   A follow-up audit, 6 months after the initial audit date, will be conducted for all provider agencies with a Not Compliant audit rating below 86% to ensure that a CAP is implemented and issues identified in the CAP are corrected.

   a. The same pre-audit and audit procedures apply with the exception that the follow-up audit period to be reviewed starts four (4) months prior to the month the audit is conducted. For example:

      Follow-up audit date: 8/1/2020 Audit Period: 4/1/2020 – 4/30/2020
      Follow-up audit date: 1/15/2021 Audit Period: 9/1/2020 – 9/30/2020

   b. DDD Fiscal Section shall follow the Audit procedure above,
   c. A Provider that receives a Not Compliant follow-up audit result for two (2) consecutive years will be issued a letter of termination from DHS-MQD.

C. Independent Audits

There are no state requirements for Providers to complete Independent Audits. Independent financial audits conducted by a Certified Public Accountant (CPA) are recommended and considered best practice as they produce a work product from an independent examination of financial records, accounts, business transactions, accounting practices, and internal controls, and can provide agencies with information, tools, and strategies to better protect against fraudulent activities.

3.8 - MONITORING PROVIDER AGENCIES

The Provider must cooperate with the DOH-DDD and DHS-MQD, and the Centers for Medicare and Medicaid Services (CMS) or their authorized representatives, when evaluations or reviews are conducted, both announced and unannounced, on the quality, adequacy, accuracy, and timeliness of services provided. The following pertain to evaluations or reviews:

- Provider records must be maintained in a current and organized manner in order to be readily available to the waiver program monitors and/or fiscal monitors at the time of a site review or upon request.
- Evaluations or reviews may be in-person at the Provider's location or as a desk audit. The following may occur:
  - review of administrative, fiscal, quality assurance and personnel records;
  - review of program and participant records, including but not limited to, documentation of service delivery, progress notes, reports, time and efforts for participants, and documentation of observations/reviews of service delivery.

A. DOH-DDD Responsibilities

The DOH-DDD is responsible for monitoring compliance and ensuring that Providers of Medicaid I/DD Waiver services adhere to requirements of the 1915(c) waiver approved by CMS and the Waiver Standards.

1. Program Monitoring

   a. Notification of Scheduling and Sample

      1) DOH-DDD issues scheduling letters to Providers thirty (30) calendar days before the monitoring date. The scheduling letter includes the review approach, review date, review period and the required documentation for monitoring.
      2) The sample is determined by randomly selecting from a list of the total number of participants served by each Provider.

   b. Location and Approach

      DOH-DDD determines the most efficient and effective manner to monitor Providers, which may include an on-site visit to complete record reviews at the Provider's main office; visits and observations of direct service delivery at the participant's location; surveys and interviews; and/or record reviews completed as a desk audit.

For desk audits at DOH-DDD, the Provider will submit copies of records or files by secured mail, in-person delivery to the DOH-DDD-CRB office or encrypted electronic files. Originals will not be accepted.

c. Frequency of Review

Monitoring will be conducted on an annual basis or more frequently as determined by DOH-DDD. The program monitoring period requires a review of one year of program records. The program monitoring period will include a full 12 month period that ends one (1) month prior to the monitoring date. For example, for a monitoring visit on January 24, 2021, records from January 2020 through December 2020 will be evaluated.

d. Required Documentation for Program Monitoring

The scheduling letter will specify the documents required for review. Program monitoring reviews provider records which may include, but not limited to, the following:

1) Individualized Service Plan (ISP) and Individual Plan (IP),
2) Strategies, protocols and supports to address identified risks and safety concerns,
3) Behavior Support Plans (if applicable),
4) Evidence of staff training,
5) Reports (quarterly or more frequent),
6) Documentation of face-to-face observations/reviews of service delivery,
7) Adverse Event Reporting and internal quality assurance activities,
8) A copy of agency's current general liability insurance certificate and automobile insurance certificate covering the organization.

e. Findings

1) Results from the monitoring will be issued to the Provider within 30 calendar days after the final date of the review.
2) Findings, including the remediation required by Provider agencies through corrective action plans, are reported on the Quality Assurance/Improvement Provider Monitoring Tool (monitoring tool) (see Appendix 8D). The monitoring tool is used as a data source for waiver performance measures. DHS-MQD tracks and reports these waiver performance measures to CMS.

2. Validation of Provider Staff and Licensed/Certified Caregiver Qualifications

The validation process begins at least one month prior to the program monitoring in order to give sufficient time to review staff qualification documents prior to the on-site monitoring

visit. Provider qualification requirements are specified in Section 3.4 General Staff Qualification Requirements and service-specific qualifications are described in Section 4.

a. Notification of Scheduling and Sample

1) DOH-DDD issues scheduling letters to Providers thirty (30) calendar days before the monitoring date. The Provider must submit a consolidated list of all staff and licensed/certified caregivers providing waiver services within fourteen (14) calendar days.

2) Once the consolidated list is received, DOH-DDD randomly selects a sample of current workers, who provide direct service to participants, and will notify the Provider of the names of workers selected. The sample size for current workers is a minimum of twenty (20) employees or 10% (whichever is greater). The sample size for new workers (i.e. workers hired within 12 months of the review date), service supervisors and licensed or certified workers is 100%.

b. Location and Approach

DOH-DDD determines the most efficient and effective manner to complete the validation process, which may include an on-site visit to complete record reviews at the Provider's main office and/or record reviews completed as a desk audit.

For desk audits at DOH-DDD, the Provider will submit copies of records or files by secured mail, in-person delivery to the DOH-DDD-CRB office or encrypted electronic files. Originals will not be accepted.

c. Frequency of Review

Validation of staff qualification requirements is conducted on an annual basis.

d. Required Documentation for Validation Review

The Provider will complete the Provider Validation Spreadsheet for current workers and for new workers, if applicable, and prepare copies of all supporting documents. Required documentation is listed in Appendix 7E, Spreadsheet for Validation of New and Current Provider Staff.

e. Findings

Based on findings, DOH-DDD issues a letter to the Provider.

1) If all workers were validated, a letter indicating 100% compliance is sent to the Provider.
2) If documents were missing or incomplete, a letter documenting the outstanding validation issues is sent to the Provider. The Provider must respond within the timeline specified in the letter. Providers shall not permit any worker that is not in compliance with the staff qualification requirements to work directly with waiver participants, unless under continuous line-of-sight supervision by a properly validated staff. Continuous line-of-sight means the staff must be within eyesight and never left unattended with a participant until cleared to work by meeting all staff qualification requirements.
3) Findings, including the remediation required by Provider agencies through corrective action plans, are reported on the Completed Validation List of Employees and Independent Contractors (see Appendix 7H). The list is used as a data source for waiver performance measures. DHS-MQD tracks and reports these waiver performance measures to CMS.

3. Special Monitoring Reviews & Investigations

The DOH-DDD may conduct unannounced or short-notice visits or request for provider records, in addition to the annual monitoring and without providing the Provider with the typical two-day notice. Special monitoring reviews and/or investigations are determined by a need identified by DOH-DDD, including but not limited to:

a. issue(s) identified due to actions or inactions by the Provider;
b. situations where serious health and safety issues are identified through the AER process, mortality review or other methods;
c. at the request of the DOH-DDD Division Administrator
d. in conjunction with Case Management Branch (CMB) if issues are related to Provider performance;
e. reports of concerns or complaints received by the DOH-DDD complaints office;
f. new Providers to review for compliance with the HCBS final rule (79 FR 2947) and Waiver Standards within the first year after enrolling as a Provider; and

g. follow-up(s) on outstanding or recurrent areas requiring Corrective Action Plans.

B. Provider Responsibilities

The Provider must be prepared for monitoring evaluations, reviews and requests for records by ensuring all records are readily available, current and organized. The Provider must also be prepared to develop and implement remediation activities as needed and as identified by the DOH-DDD or other entity.

1. Corrective Action Plan (CAP)
   a. The Provider must complete and submit a CAP when deficiencies are identified during the annual monitoring. Quality improvement action statement(s) will be specified on the monitoring tool and must be addressed in the Provider's CAP.
      1) The Provider must submit the CAP within 28 calendar days. DOH-DDD may specify immediate remediation with a due date that is earlier than 28 calendar days.
      2) The CAP must specify the action(s) to be taken, the responsible staff to implement and/or the actions and the timeline for remediation to be completed.
      3) The CAP will be reviewed by DOH-DDD and the Provider will be informed in writing on the status of the CAP. If the CAP is not satisfactory, the DOH-DDD will specify additional information and clarification that are needed. The Provider must submit a revised CAP by the deadline specified. DOH-DDD may provide technical assistance to the Provider as needed.
      4) Failure by the Provider to submit a CAP that is accepted by DOH-DDD within timelines may result in sanctions imposed by DOH-DDD and DHS-MQD.
   b. The Provider must complete and submit a CAP in areas specified by DOH-DDD when deficiencies are identified during a Special Monitoring Review and/or Investigation.
      1) The Provider will be notified in writing, by the DOH-DDD, of the Special Monitoring Review and/or Investigation findings, the requirements that must be included in the CAP and the deadline for submission.
      2) The CAP will be reviewed by DOH-DDD and the Provider will be informed in writing on the status of the CAP.

i. If the CAP is not satisfactory the Provider will be notified of the additional information and clarification that are needed and the Provider will be required to submit a revised CAP.

ii. DOH-DDD may provide technical assistance and/or more frequent monitoring, as needed.

3) Failure by the Provider to submit a CAP that is accepted by DOH-DDD within timelines may result in sanctions imposed by DOH-DDD and DHS-MQD.

2. Remediation for HCBS Final Rule (79 FR 2947) on Community Integration

Providers delivering services prior to the previous Waiver renewal effective July 1, 2016, must use the transition period to complete Evidence Template(s) for each residential and non-residential setting and develop and implement remediation plans to reach full compliance by March 2023.

3.9 - ACCOUNTABILITY AND SANCTIONS

In the event the Provider has gone through remediation activities and continues to demonstrate a pattern of non-compliance with Waiver Standards, the DOH-DDD is responsible for developing a specific process for working with the Provider to improve quality and performance through DOH-DDD findings and requirements.

Depending on the type and severity of non-compliance, DOH-DDD can impose sanctions.

A. Accountability Activities

Providers under a Corrective Action Plan (CAP) Accountability Plan may be required to take additional actions to demonstrate progress toward and maintenance of compliance with Waiver Standards. Actions may include, but not be limited to:

1. increased frequency of supervision and oversight by the Provider over its staff to ensure that staff are delivering waiver services in accordance with Waiver Standards;
2. mandatory written status reports by the Provider submitted to DOH-DDD at regular intervals specified;
3. re-training of staff in topics identified by DOH-DDD; and/or
4. mandatory Practice Improvement Project that the Provider must implement as part of its quality assurance program.

B. Sanctions

The Provider may be subject to sanctions based on a determination by DOH-DDD in consultation with DHS-MQD. DOH-DDD will assess the safety and well-being of the participants and the Provider's ability to provide services per the ISP and IP. Sanctions may include, but are not limited to:

1. DOH-DDD will initiate action to ensure the health, safety and well-being of the participants.
2. Heightened monitoring by DOH-DDD including a larger sample and/or more frequent scheduled or unannounced monitoring reviews?
3. Suspension to admit new participants for services.
4. Termination of the Medicaid Provider Agreement. This sanction must be approved in advance by DHS-MQD and the letter of termination will be issued by DHS-MQD.

C. Appeal to DHS's Decision

In the event the Provider Agreement is terminated, the Provider may appeal the DHS-MQD decision following the procedures outlines in HAR, chapter 17-1736.

SECTION 4:
SERVICE-SPECIFIC
PERFORMANCE STANDARDS

4.1 TELEHEALTH

Telehealth as a modality for service delivery may be used as an option for the following services, but must follow all requirements as stated below:

1) Community Navigator,
2) Individual Employment Supports, and
3) Training and Consultation.

LIMITS:

- Telehealth must not be used to treat emergency needs.
- Telehealth shall not be used when the participant needs the provider of the service to be physically present and/or to provide physical assistance to ensure the participant's health and safety and to meet habilitative needs.
- Service delivery via telehealth must not be the only modality of overall waiver service delivery. The participant shall have opportunities for community integration through waiver services provided in community settings.

AUTHORIZATION:

Prior to determining telehealth as a modality for service delivery, the option must be explored with the participant and their circle of support through the person-centered planning process and may only be selected when the following requirements are met:

- The participant has chosen telehealth as a modality for service delivery.
- The participant and circle of support agree that services can be provided in a manner that ensures the participant's rights to privacy and choice including a signed telehealth informed consent.
- The Provider demonstrates compliance through written assurances that services delivered via telehealth comply with HIPAA and a non-public facing, HIPAA-compliant platform will be used. The Provider must submit written assurances for review by the DOH-DDD compliance officer.
- The provider will be in a private location to ensure that others do not overhear the discussion.
- The Provider assures that the beginning of each telehealth encounter:

- begins with a check for health and safety. If there are health and safety concerns identified during telehealth, the Provider will contact appropriate emergency services and submit a report to DOH-DDD if it meets the criteria for an adverse event; and
- includes informing the participant that their information is kept private and safeguards have been taken.

The following must be discussed through the person-centered planning process and documented in the participant's ISP:

- How telehealth will be used to facilitate community integration and support the participant to meet their individual person-centered goals;
- An assessment of whether telehealth is an appropriate way to deliver the service for the participant and is not used solely for the provider's convenience;
- If accommodations are needed, how they will be provided including for those who need physical assistance or assistance with use of technology; and
- How the participant's health and safety will be ensured.

DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5):

- The use of telehealth must be documented by the provider in the participant record.
- The provider record and quarterly reports must include any issues with implementing the person-centered plan through telehealth.

4.2 - ADDITIONAL RESIDENTIAL SUPPORTS

SERVICE DESCRIPTION	Additional Residential Supports (ARS) provides a short-term, hourly direct support worker to assist the Residential Habilitation caregiver (ResHab caregiver) to support a participant who experiences a physical or behavioral change that exceeds the required level of care the caregiver must provide in accordance with licensure or certification requirements; and that prevents the ResHab caregiver from implementing ResHab services in accordance with the participant's Individualized Service Plan (ISP). The desired outcome of ARS is to stabilize and support the participant so that they may remain in the home of their choice and help to prevent loss of placement and/or prevent a crisis. The service is intended to be short-term, defined as less than sixty (60) days.
LOCATION OF SERVICE	ARS services must be provided in licensed or certified community residential settings.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	ARS shall be provided at a staff to participant ratio of 1:1.
TRANSPORTATION	Transportation is not included in this service.
HOURS OF OPERATION	ARS services are available based on the participant's needs as identified through the person-centered planning process and documented in the ISP.
REIMBURSABLE ACTIVITIES	ARS activities may include, but are not limited to: 1) assistance and training with adaptive skill development, activities of daily living and instrumental activities of daily living; 2) engaging as part of routine and typical household activities, such as doctor's visits, shopping for the household, participating in family functions and community events attended by household members; and 3) social and leisure skill development. For example, the ARS direct support worker (DSW) may be used for changes to the participant's physical abilities,

	such as following an injury or surgery that requires two people for safe lifting and transferring, or where a change in the participant's behaviors requires an additional staff to implement the behavior strategies while the participant is assessed to identify any physical, environmental or mental health issues impacting the change in behavior.
ACTIVITIES NOT ALLOWED	The ResHab caregiver or any other member of the household is prohibited from being the ARS DSW. The ARS DSW shall not provide services to other residents.
LIMITS	ARS is limited to licensed or certified community residential settings: certified Adult Foster Homes (AFH), Developmental Disabilities Domiciliary Homes (DD Doms), Adult Residential Care Homes (ARCH), Expanded Adult Residential Care Homes (E-ARCH), and Therapeutic Living Programs (TLP).
AUTHORIZATION	ARS must be prior authorized by DOH-DDD and specified in the Individualized Service Plan (ISP). ARS may be authorized up to eight (8) hours per day (maximum of 56 hours per week) for a period of less than 60 days, by the CM, with approval by the CMU supervisor and CMB section supervisor, Requests that exceed the hours and/or short-term duration must be submitted through the DOH-DDD exceptions review process. ARS is a distinct and separate service that can be billed in 15-minute increments during the ResHab day.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Licensed Professional within scope of practice per Act 205, Session Laws of Hawai'i 2018:* For participants who have a formal behavior support plan (BSP) based on Functional Behavior Assessment (FBA) that is implemented during the ARS hours, the ISP will address if T&C is required or if already authorized for the ResHab setting, if an adjustment is required to the amount and frequency of T&C. This is a

	separate service that interfaces with ARS because the qualified T&C professional will train ARS DSW implementing the BSP. *T&C – Registered Nurse (T&C-RN):* For participants who require nurse-delegated tasks to be completed during the ARS hours, the ISP will address if T&C-RN is required or if already authorized for the ResHab setting, if an adjustment is required to the amount and frequency of T&C-RN. This is a separate service that interfaces with ARS because the qualified T&C professional will train the ARS DSW doing nurse-delegated tasks. The T&C provider will work with the ARS Provider to ensure that DSWs needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the ARS Service Supervisor's responsibilities. T&C may be delivered concurrently (same 15-minute period) with ARS.*
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	Additional training requirements apply if the DSW will implement a formal behavior support plan or perform nurse-delegated tasks. 1) If the ARS service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the DSW must complete specialized face-to-face training in the implementation of the BSP which may include, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting. 2) If the participant receives an RN assessment that identifies nursing tasks that may be delegated during ARS service, the DSW delivering the service must complete specialized training on the specific tasks to be performed. Training and skills verification must be provided by the RN delegating the task(s).

	Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	If the service includes implementation of a formal BSP based on an FBA, in addition to General Standards, a) the Service Supervisor must also complete specialized face-to-face training in the implementation of the BSP that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/Service Supervisor must complete face-to-face training in the implementation of the BSP. c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge.

DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	A request for ARS must be completed by the Provider and/or licensed/certified caregiver and submitted to the CM. The Provider or licensed/certified caregiver will document the request that will include: 1) The hours of services delivered across all residents of the home and 2) Documentation of the valid reason(s) for requesting this service based on the participant's needs.; 3) The plan for phasing-out the ARS within sixty (60) days. If the service is expected to be needed beyond the 60-day limit, the Provider or licensed/certified caregiver must submit the documentation to the CM to request an extension no later than twenty-one (21) days before the end of the current approval. The CM will submit the extension request through the DOH-DDD exceptions review process. The Provider or licensed/certified caregiver will submit additional documentation upon request from DOH-DDD.

4.3 - ADULT DAY HEALTH (ADH)

SERVICE DESCRIPTION	Adult Day Health (ADH) services are furnished as specified in the Individualized Service Plan (ISP), in a non-institutional, center-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. The desired outcome of ADH is to support participants to improve in individual independence and other skill building that leads to increased community integration. ADH will primarily be used in combination with Community Learning Services-Group (CLS-G) to comprise a set of services to support participants to have a flexible mix of services. ADH services are center-based and CLS-G services are community-based.
LOCATION OF SERVICES	ADH services are provided in a non-institutional, center-based setting. The ADH setting must not limit participants to activities only provided at the ADH and must offer Community Learning Services–Group (CLS-G) opportunities that are chosen by the individual. The Provider must assure that the ADH site: 1) is clean, ventilated, and equipped with proper lighting, addresses physical safety and has adequate space for the participants served; 2) is equipped with fire extinguishers that are inspected and certified annually by a licensed sales or service representative; 3) has smoke alarms that are inspected annually; 4) has a fire safety inspection conducted annually by the fire marshal or designated county fire official for each site; or the request for an annual fire safety inspection must be documented including the efforts made by the ADH provider to secure the annual fire inspection; 5) conducts semi-annual fire drills at random times and documents fire drill outcomes, problems, and corrective actions; and

	6) provides safe and secure storage of materials with appropriate labels for: a) hazardous materials such as toxic substances and cleaning supplies; b) medication; and c) sharp containers and the disposal of sharp material; d) provides a secure space for each participant to keep personal items; and e) addresses requirements for compliance with the HCBS final rule on community integration.
SERVICE TIERS	There are three rate tiers for ADH services. ***ADH tier 1*** – for participants with SIS-based levels 1 and 2 ***ADH tier 2*** – for participants with SIS-based levels 3 and 4 ***ADH tier 3*** – for participants with -SIS-based levels 5, 6, and 7
STAFF TO PARTICIPANT RATIO	The recommended staffing ratios based on the rate tiers are: • tier 1: one (1) staff to six (6) participants • tier 2: one (1) staff to four (4) participants • tier 3: one (1) staff to three (3) participants The Provider is responsible for maintaining required staffing ratios based on the participant's ISP. For monitoring conducted by DOH-DDD, the ADH Provider must maintain documentation that the staff to participant ratio is no more than 1:6 unless otherwise specified in the participant's ISP. ADH services may be provided on a one (1) staff to one (1) participant ratio (1:1). Authorizations for an enhanced, 1:1 staff ratio is intended to be time-limited, for short-term transitions and adjustments to the ADH when exiting the Department of Education program or other circumstance that is documented and prior authorized (refer to

	Authorization for information on prior authorization requirements for 1:1 ADH services).
TRANSPORTATION	Transportation between the individual's place of residence and the ADH setting will be provided as a component of ADH services. Transporting the participant to and from their home and waiting with a participant to be picked up shall not be included in the calculation of billable ADH service delivery time. Staff and other costs associated with transporting participants to and from their home, the time spent waiting for participants to be dropped off, and the time spent waiting with participants to be picked up are included in the ADH rates.
HOURS OF OPERATION	The Provider establishes hours and days of operation based on participants' needs and interest in attending the ADH. The ADH center may choose to be open on evenings, weekends and/or holidays.
REIMBURSABLE ACTIVITIES	ADH includes, but is not limited to, activities that support the participant to acquire, retain or improve : 1) activities of daily living (ADLs); 2) instrumental activities of daily living (IADLs); 3) communication skills; 4) social skills and interpersonal relationships; 5) choice making skills; 6) problem-solving skills; 7) understanding of responsibility and teamwork; 8) exploring interests through the internet, books, or other media available at the ADH location; 9) other areas of training identified in the ISP; and 10) using the Interest Inventory to guide the participant in developing a community exploration plan that will support performing and becoming embedded in social valued roles. Each participant must complete an Interest Inventory (see Appendix 9A) when ADH services are initially authorized,

	or for ongoing ADH services, at least one month prior to their ISP meeting. The Interest Inventory will be used to guide activities chosen by the participant to identify his/her social valued roles.
ACTIVITIES NOT ALLOWED	ADH must not duplicate services provided as Community Learning Services, Discovery and Career Planning or Individual Employment Supports. ADH excludes: 1) any time spent by the participant working for pay, including contracts, enclaves, groups or individual employment, regardless of the wage paid. Paid work requiring job supports is included in Individual Employment Supports; or 2) supporting participants who independently perform activities that benefit the provider or its staff, such as performing services that would otherwise require the provider or its staff to pay for that service, such as landscaping, yard work, painting and housecleaning. This includes "volunteering" at the ADH program site. Volunteer or internship experiences are included in Discovery & Career Planning. NOTE: This does not include routine chores and activities that participants engage in to maintain their common areas, practice responsibility and teamwork. A Provider shall not bill for ADH services that occur at the same time (same 15-minute period) as another face-to-face service, including Personal Assistance/Habilitation (PAB), Community Learning Service (Group or Individual), Private Duty Nursing (PDN), Respite, Discovery & Career Planning, and Individual Employment Supports – Job Coaching. NOTE: ADH can be billed for the same 15-minute period with Individual Employment Support – Job Development

	when it is not ~~a~~ being provided face-to-face with the participant. Services must not duplicate services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations. Personal care assistance may be a component part of ADH services as necessary to meet the needs of a participant but may not comprise the entirety of the service.
LIMITS	Participants and their families are afforded choice and flexibility in how to use the annual hours authorized in the ISP.
AUTHORIZATION	ADH is authorized by the CM based on the person-centered planning process and as documented in the Individualized Service Plan (ISP). If the participant's request exceeds the Individual Supports Budget amount, the participant has the option to request a review through the DOH-DDD exceptions review process. Requests for ADH to be provided at an enhanced, 1:1 staff ratio, are considered on a case-by-case basis and must be reviewed through the DOH-DDD exceptions review process. Authorizations for an enhanced staff ratio is intended to be short-term, defined as up to six (6) months. Requests for ADH 1:1 at the RBT rate must only be for the time that requires the RBT to implement the formal behavior support plan developed from the Functional Behavior Assessment. If the RBT is delivering ADH services that do not require implementing a formal behavior support plan, ADH will be authorized at the participant's ADH tier, not the RBT rate.

INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Licensed Professional within scope of practice per Act 205, Session Laws of Hawai'i 2018*: For participants who have a formal behavior support plan (BSP) based on a Functional Behavior Assessment (FBA) that is implemented during the provider's combined authorization of ADH and CLS-G service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with ADH because the qualified T&C professional will train ADH staff implementing the BSP. *T&C – Registered Nurse (T&C-RN)*: For participants who require nurse-delegated tasks to be completed during the provider's combined authorization of ADH and CLS-G service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with ADH because the qualified T&C professional will train ADH staff doing nurse-delegated tasks. The T&C Provider will work with the ADH Provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the ADH service supervisor's responsibilities. T&C may be delivered concurrently (same 15-minute period) with ADH service.*
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	**ADH (all tiers)** Additional training requirements if the Direct Support Worker (DSW) or Registered Behavior Technician (RBT) will implement a formal behavior support plan or perform nurse-delegated tasks: 1) If the ADH service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the DSW/RBT who provides the service must also complete:

	a) the DSW must complete specialized face-to-face training in the implementation of the BSP that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) if the worker is a RBT, the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP. c) for either a DSW or RBT implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. 2) If the participant receives an RN assessment that identifies nursing tasks that require delegation during ADH service, the DSW/RBT delivering the service must meet state delegation requirements per HRS 457-2.5 and 457-7. Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	If the service includes implementation of a formal BSP based on an FBA, in addition to General Standards, a) the Service Supervisor must also complete specialized face-to-face training in the implementation of the BSP that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or

	b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/Service Supervisor must complete face-to-face training in the implementation of the BSP; and c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	1) ADH providers must maintain documentation for each participant’s Interest Inventory (see Appendix 9A), including: a) the date the Inventory was completed; how the interests were identified; b) the social valued role(s) chosen by the participant; c) how the identified social valued role(s) promote positive recognition; d) frequency of community engagement with individuals who do not have disabilities and who are not paid staff; and e) how the activity relates to the participant’s interests.

	The Interest Inventory must be updated at least annually or more frequently as new interests are identified. All participants receiving ADH services must have a completed Interest Inventory. Provider must complete the Interest Inventory prior to the ISP meeting to provide the information to the participant and Circle of Supports for planning and identifying goals and outcomes for the next year. 2) The Provider must maintain documentation that ratios are maintained in compliance with the tiers. 3) When additional training is required by Staff Qualifications and Service Supervision Qualifications, the Provider must maintain documentation of all face-to-face training(s) of the BSP conducted by the licensed professional or qualified designee for the DSW, RBT, and service supervisor(s). Documentation must be available for review by DOH-DDD upon request. 4) When additional training is required by Staff Qualifications and Service Supervision Qualifications, the Provider must maintain documentation for the DSW, RBT, and service supervisor(s) of completion of comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-*DDD P&P #2.01 for Restrictive Interventions.* 5) HCBS Final Rule Modifications to Participant Access: The Provider must ensure compliance with the HCBS final rule (79 FR 2947) and that the staff do not restrict, limit, or modify the participant's access to the community. See Section 3.2 for details.

4.4 - ASSISTIVE TECHNOLOGY (AT)

SERVICE DESCRIPTION	Assistive Technology (AT) includes items, devices, pieces of equipment, or product systems, whether acquired commercially, modified or customized, that are used to increase, maintain, or improve functional capabilities of participants. The assistive technology must be for the use of the participant and necessary as specified in the ISP to assist the participant in achieving their goals, must have high potential to increase autonomy and reduce the need for physical assistance, and must be the most cost-effective option. All items must be ordered by a practitioner with prescriptive authority in accordance with Hawai‘i state law. An order is valid for one year from the date it was signed.
LOCATION OF SERVICE	AT will be used by the participant in locations that are customary to the participant.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.
TRANSPORTATION	Not included in this service.
REIMBURSABLE ACTIVITIES	AT includes: 1) assisting the participant to select, purchase, lease, or acquire assistive technology devices; 2) designing, fitting, customizing, adapting, programming, applying, maintaining, repairing or replacing assistive technology devices; 3) purchase cost of the assistive technology device; and 4) coordinating with the DOH-DDD Case Manager to obtain any necessary therapies, interventions, or services with assistive technology devices.
ACTIVITIES NOT ALLOWED	The purchase, training and upkeep of service animals are excluded.

	Internet service, laptops, personal computers and cell phones are excluded. AT purchased through the waiver is not intended to replace devices and services under the State Plan. AT that can be covered under the State Plan are provided through the QUEST Integration health plans, including Early Periodic Screening Diagnosis and Treatment (EPSDT) or through another program such as the Department of Education or Division of Vocational Rehabilitation. Assessment and training are excluded from this service and are covered under Training and Consultation (T&C). An assessment from the Department of Education or other program or insurance, completed by a qualified occupational therapist (OT), physical therapist (PT) or speech language pathologist (SLP), may be used in place of T&C waiver services if it is dated within one year of the request for the AT.
LIMITS	Commercially-available technology such as tablets and software applications are available only for the purposes of communication. The purchase of tablets must include the cost of the extended warranty and protective case. Replacement of AT may be made when an assessment determines that it is more cost-effective to replace rather than repair the item and must not occur more frequently than once a year for low-technology AT or once every two years for customized, adapted or higher-technology AT. Low-technology AT means a commercially available item or device that can be used by the participant "off the shelf" and/or items that cost less than $500.00. Higher-technology AT means an item or a device that may require customizing or adapting after purchase to meet the participant's unique needs and/or costs more than $500.00.
AUTHORIZATION	AT may be authorized by the CM with approval of Unit Supervisor and Section Supervisor.

	AT is a one-time purchase and the service ends once the participant has received the AT and training has been completed.
INTERFACE WITH TRAINING AND CONSULTTION (T&C)	Training and Consultation (T&C) – Occupational Therapist (OT), Physical Therapist (PT), Speech or Environmental Accessibility Adaptation Clinician: The assessment of the need for assistive technology is completed by a qualified T&C professional. Assessments for Assistive Technology cannot be bundled with an assessment for Specialized Medical Equipment or Environmental Accessibility Adaptations, which must be authorized separately by the DOH-DDD CM. The participant must be offered a choice of providers and can select a different qualified provider for the assessment and/or training needed for the Assistive Technology. The T&C professional must not have any conflict of interest with any vendor or business that provides the assistive technology. The T&C provider will work with the AT Provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.4, Table 3.4-1, Vendor in Column H)	AT can be provided by either of the following: 1) Waiver Provider approved by DOH-DDD to deliver AT. 2) Vendor that meets applicable state licensure, registration, and certification requirements (be authorized by the manufacturer to sell, install, and/or repair equipment if applicable and ensure that all items meet applicable standards for manufacture, design, and installation).
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	There are no additional supervision required once the AT is in use by the participant and training has been completed.

DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation is maintained in the file of each participant that the AT is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) or covered under EPSDT or the State Plan through the QUEST Integration health plans or covered by other insurance. If the AT would have been covered but the plan rules were not followed, the AT must not be purchased using waiver funds. Documentation is maintained in the participant's file of the date the AT is received, the date(s) that the participant and others have been trained in its use, and signature(s) of the participant/family affirming that the AT meets the participant's needs.

4.5 - CHORE

SERVICE DESCRIPTION	Chore services support participants to maintain the home as a clean, sanitary and safe environment in order to ensure the participant's health and welfare. Chore may be provided by DSWs of a Provider or through the Consumer-Directed (CD) option. Chore is subject to Electronic Visit Verification (EVV). See Introduction, E. and Section 3.2 for details.
LOCATION OF SERVICES	Chore must be provided in the private home where the participant resides.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	If more than one participant lives in the same home and are receiving Chore, the number of authorized units will be divided between the participants. For example, if four hours of Chore are authorized for two participants living together, Chore would be authorized for two hours for each participant, totaling four hours of Chore in the home.
TRANSPORTATION	Transportation is not included in this service.
REIMBURSABLE ACTIVITIES	Chore may include heavy household chores such as: 1) washing floors, windows and walls, 2) tacking down loose rugs and tiles, and 3) moving heavy items of furniture, in order to provide safe access and egress. Chore may also include more routine or regular services such as meal preparation and routine household care for the participant only. Chore may be provided without the participant present at the time of service delivery.
ACTIVITIES NOT ALLOWED	Chore may not be authorized for participants who live independently or with family where either the participant or family in the family home are able to perform this service. Chore may not be provided in licensed or certified settings.

	Chore provided in the family home may not include house maintenance such as yard work, house painting, and minor repairs. For participants living independently in their own home, such basic maintenance chore services may be considered on a case-by-case basis. Chore may not be provided to children under 18 years of age. Chore may not be provided to a participant by their spouse. Chore does not include meal preparation and routine household care for other members of the household.
LIMITS	Chore is available to participants living in their own place of residence who need Chore services and are without natural (non-paid) supports; or who are living with family but the members of the household are physically unable to perform the chores. Routine or regular services are provided for the participant only.
AUTHORIZATION	Chore is authorized by the CM based on the person-centered planning process and as documented in the ISP. If the participant's request exceeds the Individual Supports Budget amount, the participant has the option to request a review through the DOH-DDD exceptions review process.
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	There are no additional qualification requirements.
GENERAL SERVICE SUPERVISOR	Face-to-face observations/reviews of services being delivered to participant must be conducted quarterly or

QUALIFICATIONS (These are in addition to requirements in Section 3.4)	more frequently if indicated in the ISP and/or Action Plan. On-site supervision of Chore must consist of verification of service completion and participant satisfaction as documented in the quarterly report to the CM. For CD Chore, the employer supervises the DSW/employee.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation must indicate that no other party is capable of and responsible for providing chore services, including the participant or anyone else financially providing for the participant.

4.6.1 - COMMUNITY LEARNING SERVICES - GROUP (CLS-G)

SERVICE DESCRIPTION	Community Learning Services—Group (CLS-G) support the participant's integration in the community. Services will meet the participant's needs and preferences for active community participation, including the participant's choice whether to do the activity individually using CLS-Individual (see Section 4.6.2) or with a small group of others who share that interest using CLS-G. The intended outcome of CLS-G is to improve the participant's access to the community through increasing skills, improving communication, developing and maintaining friendships, gaining experience with the opportunities available in the community such as public events and enrichment activities, functioning as independently as possible, and/or relying less on paid supports. CLS-G will primarily be used in combination with Adult Day Health (ADH) delivered by the provider of both the ADH and CLS-G. CLS-G can also be used by participants separate from the ADH. For example, a participant may choose to do activities in the community with a small number of friends on the weekend and may use CLS-G and select the provider.
LOCATION OF SERVICE	CLS-G services are provided within the community in locations where the participant has opportunities to engage with members of the community who do not have a disability.
SERVICE TIERS	Community Learning Service – Group (CLS-G) has three service tiers. ***CLS-G tier 1***: includes participants identified by the Supports Intensity Scale (SIS) levels 1 and 2. ***CLS-G tier 2***: includes participants identified by the Supports Intensity Scale (SIS) levels 3 and 4.

	CLS-G tier 3: includes participants identified by the Supports Intensity Scale (SIS) levels 5, 6 and 7.
STAFF TO PARTICIPANT RATIO	The recommended staffing ratios during CLS-G services are: • tier 1: one (1) staff to three (3) participants • tier 2: one (1) staff to two (2) participants • tier 3: two (2) staff to three (3) participants For monitoring conducted by DOH-DDD, the Provider must maintain documentation that the staff to participant ratio is no more than 1:3 during community-based services unless otherwise specified in the participant's ISP. Providers must consider participants' community interests as the primary strategy for forming groups of participants, not only grouping by the participants' tiers.
TRANSPORTATION	CLS-G includes transportation in the provider's rate paid for the service. The Provider may meet this requirement by the CLS-G worker driving the participant from the starting location to and from the community activity or paying for public transportation if available. The CLS-G staff time spent transporting the participants to community settings during the service times is billable.
HOURS OF OPERATION	CLS-G services are available based on the participant's preferences and needs as identified through the person-centered planning process and documented in the ISP.
REIMBURSABLE ACTIVITIES	CLS-G includes, but is not limited to, services that assist the participant to: 1) acquire, retain, or improve social and networking skills, 2) develop and retain social valued roles, 3) independently use community resources, 4) develop adaptive and leisure skills and hobbies, and 5) exercise civil rights and self-advocacy skills required for active community participation. CLS-G must provide age-relevant opportunities to interact with peers.

ACTIVITIES NOT ALLOWED	CLS-G services may not be provided out of the state. CLS-G services must not duplicate or be provided at the same period of the day (same 15-minute period) as any other service that is being delivered face-to-face with the participant, such as Personal Assistance/Habilitation (PAB), Individual Employment Supports – Job Coaching, Adult Day Health (ADH), Discovery & Career Planning or Respite. NOTE: CLS-G can be billed for the same 15-minute period with Individual Employment Support – Job Development when it is not being provided face-to-face with the participant. CLS-G services may not be provided to a participant by their spouse. Personal care/assistance may be a component of CLS-G as necessary to meet the needs of a participant but may not comprise the entirety of the service.
LIMITS	Participants and their families are afforded choice and flexibility in how to use the annual hours authorized in the ISP.
AUTHORIZATION	CLS-G is authorized by the CM based on the person-centered planning process and is documented in the Individualized Service Plan (ISP). If the participant's request exceeds the Individual Supports Budget amount, the participant has the option to request a review through the DOH-DDD exceptions review process.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Professional practicing within the scope of their license and in accordance with Act 205, Session Laws of Hawai'i 2018:* For participants who have a formal behavior support plan (BSP) based on a Functional Behavior Assessment (FBA) that is implemented during CLS-G service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with CLS-G because the

	qualified T&C professional will train CLS-G staff who will implement the BSP. *T&C – Registered Nurse (T&C-RN):* For participants who require nurse-delegated tasks to be completed during CLS-G service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with CLS-G because the qualified T&C professional will train CLS-G staff who will perform nurse-delegated tasks. The T&C Provider will work with the CLS-G Provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the Provider Service Supervisor's responsibilities. T&C may be billed at the same time (same 15-minute period) as the CLS-G service.*
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	All CLS-G staff must complete specialized training in community integration. Additional training requirements if the Direct Support Worker (DSW) or Registered Behavior Technician (RBT) will implement a formal behavior support plan or perform nurse-delegated tasks: 1) If the ADH service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the DSW/RBT who provides the service must also complete: a) the DSW must complete specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) if the worker is a RBT, the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP.

	c) for either a DSW or RBT implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. 2) If the participant receives an RN assessment that identifies nursing tasks that require delegation during ADH service, the DSW/RBT delivering the service must meet state delegation requirements per HRS 457-2.5 and 457-7. Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	If the service includes implementation of a formal BSP based on a FBA, in addition to General Standards, a) the Service Supervisor must also complete specialized face-to-face training in the implementation of the BSP that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/service supervisor must complete face-to-face training in the implementation of the BSP. c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in

	accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	1) The provider must maintain a copy of sign-in sheets as documentation of all face-to-face worker training(s) conducted by the licensed professional or qualified designee for instructing workers in how to implement a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA). 2) The provider must maintain a copy of sign-in sheets as documentation of all skills verification done for nurse-delegated tasks by the Registered Nurse who delegates the tasks.

4.6.2 - COMMUNITY LEARNING SERVICES - INDIVIDUAL (CLS-IND)

SERVICE DESCRIPTION	Community Learning Services-Individual (CLS-Ind) support the participant's integration in the community. Services will meet the participant's needs and preferences for active community participation, including the participant's choice of whether to do the activity individually using CLS-Ind or with a small group of others who share that interest using CLS-Group (see Section 4.6.1). The intended outcome of CLS-Ind is to support the participant to access the community in a manner that best meets their choices and interests. CLS-Ind includes assistance and supervision for community activities to maintain, learn or improve skills; develop social roles valued by non-disabled members of the community; use community resources; pursue leisure skills and hobbies; exercise civil rights and self-advocacy skills required for active community participation; functioning as independently as possible, and/or relying less on paid supports. CLS-Ind may be provided by staff of a Provider or through the Consumer-Directed (CD) option. CLS-Ind is available to participants of all ages.
LOCATION OF SERVICES	CLS-Ind services are provided within the community in locations where the participant has opportunities to engage with members of the community who do not have a disability. CLS-Ind must be delivered only in integrated settings in the community, outside the participant's place of residence.
SERVICE TIERS	This service does not include any tiers.
STAFF TO PARTICIPANT RATIO	Provider agencies provide CLS-Ind at a ratio of • 1:1 – one (1) staff to one (1) participant

	or at an enhanced staff ratio of • 2:1 – two (2) staff to one (1) participant • 3:1 – three (3) staff to one (1) participant CLS-Ind provided at a participant's workplace for work-based activities may be provide at a ratio of • 1:1 – one (1) staff to one (1) participant • 1:2 – one (1) staff to two (2) participants • 1:3 – one (1) staff to three (3) participants A Registered Behavior Technician (RBT) may provide CLS-Ind at a 1:1 ratio or an enhanced staff ratio with the following requirements: • Enhanced staff ratios must include a minimum of one RBT • 2:1 or 3:1 – At least one of the staff in each ratio must be an RBT For Consumer-Directed, one Consumer-Directed employee may deliver CLS-Ind services at a ratio of: • 1:1 –one (1) employee to one (1) participant, or • 1:2 – one (1) employee to two (2) participants
TRANSPORTATION	CLS-Ind includes transportation in the provider's rate paid for the service. The provider may meet this requirement by the CLS-Ind worker driving the participant from the starting location to and from the community activity, paying for public transportation if available, or paying for another mode of transportation for the participant to get to and from the community activity, regardless of whether the CLS-Ind staff transports the participant or meets the participant at the location. The CLS-Ind staff time spent transporting the participant to community settings during the service times is billable. For CD, the CLS-Ind employee must be paid for time spent transporting the participant to community

	settings round-trip from the participant's home or other location chosen by the participant to start and/or end the CLS-Ind activity. The participant may not use Non-Medical Transportation to transport the participant to CLS-Ind service or during CLS-Ind service hours. The participant may not use CLS-Ind if the sole purpose of the service is for transportation.
HOURS OF OPERATION	CLS-Ind services are available based on the participant's preferences and needs as identified through the person-centered planning process and documented in the ISP. This includes a schedule chosen by the participant to receive CLS-Ind during the day, evening, weekends, and holidays.
REIMBURSABLE ACTIVITIES	CLS-Ind may include, but is not limited to, assisting the participant to maintain, learn or improve skills to: 1) develop social and networking skills, 2) develop and retain social valued roles, 3) independently use community resources, 4) develop adaptive and leisure skills and hobbies (including hobbies that result in a microenterprise), and 5) exercise civil rights and self-advocacy skills required for active community participation. CLS-Ind must provide age relevant opportunities to engage with members of the community who do not have a disability. For children, CLS-Ind is used to support the goals and outcomes identified in the ISP that involve age-appropriate activities with their peers in locations where children gather, engaging with other children with similar interests, and building relationships with peers outside of school. As children reach their teen years, CLS-Ind also includes developing and identifying interests that could lead to exploring, discovery and planning for

	competitive integrated employment through the Discovery and Career Planning service. CLS-Ind may be used by participants for ongoing supports to volunteer at non-profit organizations or to work in competitive integrated employment. The responsibilities of CLS-Ind direct support worker, in volunteer or competitive integrated employment, may focus on habilitative training and/or assistance in activities of daily living, such as eating, toileting, mobility and transfers, and assistance with job duties that would not be typically provided by co-workers or supervisors at the volunteer or work site. The need for ongoing supports using CLS-Ind in volunteer or work settings, is made based on an assessment by the CM, at least annually, as part of the person-centered planning process.
ACTIVITIES NOT ALLOWED	CLS-Ind may not be provided out of the country. For participants under age 21, CLS-Ind may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration (QI) health plans. CLS-Ind services may not be delivered during educational hours on school days as defined in the Individualized Education Plan (IEP) for a student (age 3 to 21) who is attending school, such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the Medicaid I/DD Waiver will not provide CLS-Ind services during the times when the participant would otherwise be attending school. These limits do not apply once an adult has graduated or exited school.

	CLS-Ind may not be used to help a student complete school homework assignments. CLS-Ind may not be used for the sole purpose of child care while parents work outside the home. CLS-Ind may not replace the responsibilities of the family to include the participant who is a minor child in typical family activities in the community. CLS-Ind services may not be provided to minor children, less than 18 years of age, by parents, step-parents, or the legal guardian of the minor. CLS-Ind services may not be provided to a participant by their spouse. CLS-Ind in volunteer or employment settings may not be used: a) in employment settings that are not competitive integrated employment b) for the sole purpose of transporting the participant to and from the job; c) to replace the employer's responsibility for supervision, training, support and adaptations typically available to other workers without disabilities; d) to increase productivity of any company or business that employs a participant; e) as a condition of employment where the employer requires the participant to have a CLS-Ind worker with the participant at all times. An individual serving as a designated representative for a waiver participant using the CD option may not provide CLS-Ind. CLS-Ind may not be provided at the same time (in the same hour of the day) as Respite, Personal Assistance/Habilitation, Adult Day Health, Discovery and Career Planning, or Individual Employment Supports.

	NOTE: CLS-Ind can be billed for the same 15-minute period with Individual Employment Support – Job Development when it is not ~~a~~ being provided face-to-face with the participant. CLS-Ind does not include educational services otherwise available through a program funded under section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations. Personal care/assistance may be a component of CLS-Ind as necessary to meet the needs of a participant but may not comprise the entirety of the service.
LIMITS	Out-of-state CLS-Ind services cannot exceed 14 calendar days in the participant's plan year for one staff to accompany the participant. An exceptions process is in place for situations that could arise during travel that would require additional authorization of hours. Out-of-state CLS-Ind is approved for the same number of hours as the current authorization. For participants using the CD option, out-of-state CLS-Ind is combined with CD PAB. The daily limit for CLS-Ind is 16 hours (64 units). ~~CLS-Ind is not intended to be used on an ongoing or long-term basis to support a participant to work except for the primary purpose of assisting the participant with activities of daily living.~~
AUTHORIZATION	CLS-Ind is authorized by the CM based on the ISP. If the participant's request exceeds the Individual Supports Budget amount or service guidelines, the

	participant has the option to request a review through the DOH-DDD exceptions review process. For Provider CLS-Ind: The staff to participant ratio for CLS-Ind services is 1:1. Requests for enhanced staff authorizations (2:1 or 3:1 ratios) are considered on a case-by-case basis and must be reviewed through the DOH-DDD exceptions review process. Enhanced staff authorizations for Provider CLS-Ind (2:1 or 3:1) must be reviewed at regular intervals as specified in the ISP or a minimum every six months to determine the continued need for enhanced staffing. CLS-Ind may be authorized at the RBT rate for the hours specified in the ISP that require the RBT to implement the formal behavior support plan developed from the functional behavior assessment. If the RBT is delivering CLS-Ind services that do not require implementation of a formal behavior support plan, CLS-Ind will be authorized at the regular DSW rate, not the RBT rate. CLS-Ind is generally not provided by any worker or member of the ResHab household (someone residing at the same address as the participant). If the participant lives in a ResHab setting and the participant chooses to receive CLS-Ind from any worker or member of the ResHab household, the ISP must clearly document that the CLS-Ind service: 1) is distinct from routine household and family activities provided as part of the ResHab service; 2) is used by the participant for activities in the community that are chosen by the participant; and 3) includes that the participant has been given an informed choice of workers and is not limited

	only to the ResHab workers or household members. Before CLS-Ind can be provided by any worker or member of the ResHab household, prior authorization from DOH-DDD is required.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Professional practicing within the scope of their license and in accordance with Act 205, Session Laws of Hawai'i 2018:* For participants who have a formal behavior support plan (BSP) based on a Functional Behavior Assessment (FBA) that is implemented during CLS-Ind service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with CLS-Ind because the qualified T&C professional will train CLS-Ind staff or CD employees who will implement the BSP. *T&C – Registered Nurse (T&C-RN):* For participants who require nurse-delegated tasks to be completed during CLS-Ind service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with CLS-Ind because the qualified T&C professional will train CLS-Ind staff or CD employees who will perform nurse-delegated tasks. The T&C Provider will work with the CLS-Ind Provider and CD employer to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the provider Service Supervisor's responsibilities. T&C may delivered concurrently (same 15-minute period) with CLS-Ind.*

STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	All CLS-Ind staff must complete specialized training in community integration. Additional training requirements if the Direct Support Worker (DSW) or Registered Behavior Technician (RBT) will implement a formal behavior support plan or perform nurse-delegated tasks: 1) If the CLS-Ind service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the DSW/RBT who provides the service must also complete: a) the DSW must complete specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) if the worker is an RBT, the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP. c) for either a DSW or RBT implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. 2) If the participant receives an RN assessment that identifies nursing tasks that require delegation during CLS-Ind service, the DSW/RBT delivering the service must meet state delegation requirements per HRS 457-2.5 and 457-7. Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
PROVIDER QUALIFICATION STANDARDS	The CD employee must be a Direct Support Worker (DSW) who completes the mandatory qualifications:

(These are in addition to General Standards, See Section 3.4) **DSW – Consumer-Directed Employee**	1) Mandatory: a) Criminal History name check; and b) Satisfactory skills (skill level as defined and identified in the ISP) as verified and documented by the employer prior to the service delivery and in the event of any changes to the ISP, including required training and skills verification for nurse delegated tasks or in implementing a formal Behavior Support Plan (BSP); 2) Recommended: In addition, it is recommended that the consumer-directed employee complete the recommended qualifications: a) national criminal history checks, Adult Protective Services (APS) and/or Child Welfare Services (CWS) checks according to the Standards set forth by the DHS; b) TB clearance; c) First Aid training; and d) Cardiopulmonary Resuscitation (CPR) training.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	If the service includes implementation of a formal BSP based on an FBA, in addition to General Standards, a) the Service Supervisor must also complete specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/Service Supervisor must complete face-to-face training in the implementation of the BSP. c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system

	compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge. For CD, the employer supervises the employee(s). The CD employer must ensure that all CD employees performing nurse-delegated tasks or implementing a formal Behavior Support Plan (BSP) have successfully completed all required training and skills verification.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	1) The Provider or CD employer must maintain a copy of sign-in sheets as documentation of all face-to-face training(s) conducted by the licensed professional or qualified designee for instructing workers in how to implement a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA). 2) The Provider or CD employer must maintain a copy of sign-in sheets as documentation of all skills verification done for nurse-delegated tasks by the Registered Nurse who delegates the tasks.

4.7 - COMMUNITY NAVIGATOR

SERVICE DESCRIPTION	Community Navigator services emphasize, promote and coordinate the use of community resources and natural supports to address the participant's needs in addition to paid services. Community Navigator services are designed to strengthen participants' social valued roles in their community and assist the participant to identify, connect, participate and fully engage in integrated community activities and resources of interest to the participant in accordance with their ISP goals. The service is time limited. A skilled Community Navigator can help participants and their circle to identify, develop and expand social and community networks and overcome challenges in identifying and joining groups and activities. The Community Navigator supports the participant to get started in their chosen community activities by performing advance work to engage with community groups, then provide coaching/modeling with the participant as they join the group or activity. If the participant needs ongoing support to participate in the community group or activity, CLS may be authorized and the Community Navigator will fade. Integrated community activities and resources are those that are available to and utilized by all members of the community. Some typical examples may include coordinating and establishing activities such as: a) volunteer opportunities; b) adult education (college, vocational training, and other educational opportunities); c) community-based classes for learning new skills or developing hobbies or leisure/cultural interests;

	d) formal or informal associations and/or community groups; e) civic engagement; f) self-determination and self-advocacy skills; g) physical activities (affiliations with sports teams); and h) broad range of community settings and activities that enable the participant to make community connections. This service is available to children and adults.
LOCATION OF SERVICES	Community Navigator services are provided within the community in locations of the participant's choice and where they have opportunities to engage with members of the community who do not have a disability. This service may be delivered via telehealth. See Section 4.1 for details.
SERVICE TIERS	This service does not include tiers.
STAFF TO PARTICIPANT RATIO	The ratio is one (1) staff to one (1) participant.
TRANSPORTATION	Transportation should not be the primary activity of this service, but may be a focus of planning with the participant to sustain their community integration. CLS may be authorized in the ISP to support the participant with learning to use transportation. resources. Time spent transporting to community settings during service times is billable. The Community Navigator may transport the participant to and from the community activity on a temporary, transitional basis to assist the participant to support community integration while working with their CLS worker to learn how to arrange and use transportation on an ongoing basis, if applicable.

HOURS OF OPERATION	Community Navigator services are available based on the participant's preferences and needs as identified through the person-centered planning process and documented in the ISP.
REIMBURSABLE ACTIVITIES	Community Navigator services are primarily focused on working directly with the participant (at least 75% of the authorized time) to: a) explore their interests and support them in identifying/exploring the type of community options that can maximize their opportunities for meaningful engagement and independence; b) prepare information and tools that are individualized to aid the participant in determining which community activities and resources to pursue; c) provide advocacy and support to help guide the participant in problem solving and decision making that enhances their ability to interact and contribute in the local community; d) provide guidance, demonstration, coaching, modeling and/or assistance with the participant regarding how to access the identified integrated community activities, supports, services, and/or resources. • On-site coaching, modeling and/or assistance are intended to be brief and intermittent, not for long-term or ongoing waiver supports, such as Community Learning Services (CLS). When the Community Navigator is performing these functions, while another waiver service, such as CLS, is being utilized by the participant for ongoing support, both services may be billed at the same time; e) ensure the participant's active and appropriate utilization of the activities, supports, services and/or resources; f) provide periodic check-ins with the participant upon request to determine if any adjustments are needed; g) develop a Community Navigation plan. Services are typically delivered face-to-face with the participant. Exceptions where the participant may or may not be present include:

	a) assisting the participant in connecting to the identified, non-Medicaid funded community resources by researching, contacting the parties responsible for the activities, supports, services, and/or resources, and working with the community parties to address any preparations or accommodations the participant needs; b) consulting with the CM as needed to ensure coordination with the participant's ISP goals and outcomes; c) working with Service Supervisors of CLS services if the participant will use CLS supports during their chosen integrated community activities. The CLS Service Supervisor is responsible for training the CLS worker, assisting in the transition from Community Navigator to ongoing CLS, and monitoring ongoing performance in delivering CLS; d) other activities that are identified by the participant and circle of support to create successful community experiences for the participant, such as providing community group members with information about developmental disabilities, and training about the individual's needs and use of accommodation strategies.
ACTIVITIES NOT ALLOWED	Community Navigator personnel cannot be the direct support worker or the service supervisor of CLS services provided to the same participant.
LIMITS	Community Navigator services are limited to 80 hours per plan year. This is a distinct and unique service that does not duplicate Community Learning Services, which are paid supports a participant may use on an ongoing basis to maintain, learn, or improve skills in the community. Activities performed when the participant may or may not be present, such as researching and contacting potential sites or brokering supports, services and resources, shall not comprise more than

	twenty-five percent (25%) of the total hours authorized in the ISP. Community Navigator services will not supplant, replace, or duplicate activities that are required to be provided by the CM. Community Navigator services will not supplant, replace or duplicate services that are available to a participant under the Medicaid State Plan, any third-party payer, a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (30 U.S.C. 1401 et seq.). Telehealth will not be used during this service: a) to treat emergency needs; or b) when the participant needs the provider of this service to be physically present and/or to provide physical assistance to ensure the participant's health, safety and to meet habilitative needs.
AUTHORIZATION	Community Navigator service is authorized by the CM based on the person-centered planning process and is documented in the Individualized Service Plan (ISP). Community Navigator services are additional services and are not included in the Individual Supports Budget.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	T&C does not replace the Provider Service Supervisor's responsibilities. T&C may be delivered concurrently (same 15-minute period) with Community Navigator.
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS	Community Navigator must meet General Standards and have the experience, training, education or skill necessary to meet the participant's need for integrated community services and resources as demonstrated by a minimum of bachelor's degree in

(These are in addition to requirements in Section 3.4)	a human service field and a minimum of one (1) year of experience in providing direct assistance to individuals with disabilities to network within a local community or comparable training, education or skills and completes training in community integration. Training curriculum is at the discretion of the provider but must be pre-approved by DOH/DDD. In place of a bachelor's degree, the Community Navigator may have a high school diploma or equivalent (GED) and a minimum of two (2) years of experience providing direct assistance to individuals with developmental disabilities. The Community Navigator also acting as a Service Supervisor must have a Bachelor's Degree. The Community Navigator must be knowledgeable about resources and has demonstrated connections to the informal structures of the local community.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	It is recommended that the Service Supervisor for a participant's plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	The Individual Plan (IP) should identify targeted actions that will promote community integration and independent or naturally supported involvement. The Provider must also develop a Community Navigation plan that is linked to ISP goals/objectives and IP strategies with step-by-step approaches that can continue to be followed by the participant, family/friends, caregivers and Community Learning Services (CLS) worker, if applicable, after the service ends.

	The plan should address approaches to reduce barriers and challenges to accessing community resources and activities, as well as strategies to ensure that the participant is able to continue participating on an ongoing basis if they choose.

4.8 - DISCOVERY & CAREER PLANNING (DCP)

SERVICE DESCRIPTION	Discovery & Career Planning (DCP) combines elements of traditional prevocational services with career planning in order to provide supports that the participant may use to develop skills and interests toward becoming employed for the first time or at different stages of the participant's work career to develop skills and interests for advancement or a change in the participant's career plan. DCP is based on the belief that all individuals with intellectual and developmental disabilities can work when given the opportunity, training, and supports that build on an individual's strengths, abilities and interests. This service is designed to assist participants to: 1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in integrated community employment; 2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills and abilities. The outcome of DCP services is to complete or revise a career plan and develop the knowledge and skills needed to get a job in a competitive, integrated employment or be self-employed. The provision of DCP is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community. DCP includes **Benefits Counseling**. Benefits planning/counseling services are an important part of career decision making for participants who receive Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), and other entitlements. Benefits counselors are skilled in helping participants determine the impact of earning income on their benefits and are knowledgeable about many work incentives that may be available. Providers must:

	1) supply the participant with a list of certified benefits counselors and assist them with scheduling a Benefits Counseling session with the provider of their choice; and 2) provide instructions on how to obtain a Benefits Planning Query (BPQY) from Social Security prior to the scheduled Benefits Counseling appointment. DEFINITIONS: BENEFIT COUNSELING is a service that promotes work preparation by examining current disability benefits and assisting the individual and family to understand the impact of increased income on those benefits. FINANCIAL LITERACY is practical financial knowledge to save, budget, avoid debt, spend wisely, invest, donate, and manage other aspects of financial decision-making to enhance an individual's quality of life. DCP does not duplicate services provided by the Division of Vocational Rehabilitation.
LOCATION OF SERVICES	DCP services are primarily provided in community-based settings. Home visits may be required to fully assess the participant's interests and skills; however, the participant's residence is not a primary location for DCP services.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	The ratio is one (1) DCP staff to one (1) participant.
TRANSPORTATION	DCP includes transportation in the Provider's rate paid for the service. The provider may meet this requirement by the DCP worker driving the participant from the starting location to and from the community settings or paying for public transportation if available. The DCP staff time spent transporting the participants to community settings during the service times is billable.
HOURS OF OPERATIONS	DCP Providers must consider the needs of participants when scheduling DCP activities to ensure all aspects of the participant's life are observed, which may include weekend and evening activities.

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

	12) transporting the participant to and from DCP experiences is billable under DCP.
ACTIVITIES NOT ALLOWED	DCP is not intended to teach the participant task specific skills to perform a particular job. Participants who need support to perform their job may utilize other services such as Individual Employment Supports (IES) or Community Learning Services. DCP services must not be provided at the same time (same hour) as another face-to-face service, such as Personal Assistance/ Habilitation (PAB), Adult Day Health (ADH), Community Learning Service - Individual or Group (CLS-Ind or CLS-G), Individual Employment Supports – Job Coaching or Respite. NOTE: DCP can be billed for the same 15-minute period with Individual Employment Support – Job Development when it is not being provided face-to-face with the participant. DCP services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations. DCP excludes: 1) providing vocational services where participants are supervised for the primary purpose of producing goods or performing services, including services provided in sheltered workshops and contract work at less than minimum wage; 2) payments that are passed through to users of DCP, including payments of wages or stipends for internships or work experience; 3) paying employers incentives to encourage or subsidize the employer's participation in internships or apprenticeships; 4) supporting participants to volunteer at for-profit organizations or businesses or to independently perform services without pay ("volunteering") that benefit the

	waiver service provider or its staff and which would otherwise require the provider or staff to pay to have that service completed, such as landscaping, painting, or housecleaning; 5) supporting any activities that involve payment of sub-minimum wage; and offering services in settings that do not meet the criteria included in the service definition.
LIMITS	Personal care/assistance may be a component of DCP services, but does not comprise the entirety of the service. DCP services are limited to a maximum of 24 months of cumulative DCP with an expectation that the participant is working at the end of this period in a competitive integrated job or is self-employed. A month of DCP means a calendar month in which one or more units of DCP is provided. For a transition-age student from the age of fourteen (14) years until exiting school, DCP may be provided when the student is not engaged in any vocational training and only during non-school hours. Non-school hours are defined as not being delivered during the school day or educational hours as defined in the Individualized Education Plan (IEP) for a student who is attending school, such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the waiver will not provide DCP services during the times when the participant would otherwise be attending school. These limits do not apply once an adult has graduated or exited school.
AUTHORIZATION	DCP is authorized based on the participant's Individualized Service Plan (ISP) which shall include employment-related goals and the DCP activities designed to support the employment goals. DCP is not a pre-requisite for receiving Individual Employment Supports. The participant's ISP may include a combination of DCP and other non-residential waiver

	services. When used as a wrap-around support for participants who work part-time, DCP must be coordinated with any Individual Employment Services or any other non-residential supports the participant is receiving to reinforce participation in competitive integrated employment as a priority life activity. An extension of the authorization may be made for a second 24-month interval if the participant lost his or her job or has experienced a major gap in employment due to health or other issues.
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	Providers of employment services must have at least one Employment Specialist or Service Supervisor who is a Certified Employment Service Professional. **Employment Specialist** must have the knowledge and competency to deliver quality employment services to assist job seekers with I/DD in acquiring competitive integrated employment. An Employment Specialist also acting as a Service Supervisor must have a Bachelor's Degree. Employment Specialist will have specialized training and demonstrated competency in all of the following areas: a) Application of core values and principles in delivery of employment services: rights, history, legislation, best practice and professionalism. b) Individualized assessment and employment/career planning: assess strengths, skills, interests, situational assessment, career exploration, support plan, stakeholder involvement, paid work's impact on benefits, accommodation plan, and transition to work models. c) Community research and job development: knowledge to prepare marketing approaches and materials for job developer and job seeker (brochures, resumes, profiles and material), planning job seeker involvement and decision making, assistance with disclosure and accommodations requests, networking, development of skills for outreach and interactions with employers to

	explore their needs, as well as conducting community research including labor market information, range of employers in the area and information on specific employers or industries. d) Workplace and related supports: job analysis, starting the job, implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, ongoing supports and funding, access to resources needed for long-term employment, opportunity for career advancement, transportation planning, and ensuring work is well integrated into life activities and supports. Employment Specialists are required to complete specialized training in implementing the DCP pathway within the first two years of hire. Specialized training may be completed by completing an Association of Community Rehabilitation Educators (ACRE) certified Customized Employment curricula. **Employment Technicians** must have the knowledge and competency to provide quality employment services to job seekers with I/DD in maintaining competitive integrated employment. Employment Technicians will have specialized training and demonstrated competency in the following areas: a) Application of core values and principles in delivery of employment services: rights, history, legislation, best practice and professionalism. b) Individualized assessment and employment/career planning: assess strengths, skills, interests, situational assessment, career exploration, support plan, stakeholder involvement, work impact on benefits, accommodation plan, and transition to work models. c) Workplace and related supports: job analysis, starting the job, implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral

	supports, ongoing supports and funding, access to resources needed for long-term employment, and opportunity for career advancement. Employment Technicians are required to complete specialized training in implementing the DCP pathway within the first two years of hire. Specialized training may be completed either by completing an ACRE certified Customized Employment curricula or completing training through the DOH-DDD Discovery Community of Practice. **Benefits Counselors** must complete and maintain certification provided by an accredited university and have documentation on file with the DOH-DDD CRB to be added to the Benefits Counselor Registry. Benefits Counselors may be either an employee of the Provider or an independent contractor of the Provider.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	The Service Supervisor must complete a customized employment overview that includes the Discovery and Career Planning Pathway, job development, systematic instruction, job coaching, and benefits planning within the first two years of providing employment services. The frequency of supervision will be specified in the ISP.
DOCUMENTATION STANDARDS (in addition to General Standards, in Section 3.5)	The Discovery Process should document these steps in order: Profile I should be completed during the first quarter after authorization of the DCP goal (the 1st through 3rd months after authorization). Profile II should be completed during the second quarter (the 4th through 6th months after authorization). Profile III should be completed during the third quarter (the 7th through 9th months after authorization). (see Appendix 10C – 10E for sample Profiles) The Discovery Action Meeting should be held during the fourth quarter (the 10th through 12th months after authorization) with a Job Development Plan being competed

	as a result of the accumulated data and results from the Discovery Action Meeting. If any of the steps in the Discovery Process are not completed within the recommended time interval, the Provider must document the reasons(s) for the delay, barriers to completing, and action steps to address the barriers. Progress toward these milestones must be reviewed at regular intervals as specified in the ISP. **Benefits Counseling** The Benefits Counselor will complete a Benefits Counseling Profile and a Personalized Benefits Plan (see Appendix 10B).

4.9 - ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)

SERVICE DESCRIPTION	Environmental Accessibility Adaptations (EAA) includes those physical adaptations that are permanently installed in the participant's home (owned or rented by the participant or family with whom the participant resides), required by the participant's ISP, and necessary to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home. The EAA must be ordered by a physician or other health practitioner with prescriptive authority under Hawai'i state law. The order must be dated within one year of the request.
LOCATION OF SERVICES	EAA may only be delivered in the participant owned or rented home or family home where the participant resides and where the participant is expected to reside for at least five (5) years following the completion of the EAA.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.
TRANSPORTATION	Not included in this service.
REIMBURSABLE ACTIVITIES	EAA include the installation of ramps and grab bars; widening of doorways; modification of bathroom facilities; environmental control devices that replace the need for physical assistance and increase the participant's ability to live independently, such as automatic door openers; and the installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies that are necessary for the welfare of the participant and directly related to the participant's developmental disability. Adaptations are for homes owned by the participant and/or their legal guardian or family with documentation provided to demonstrate ownership. Adaptations may be completed on a rental property where the property owner has agreed in writing to the adaptation and will not require that the property be restored to the previous floorplan or condition.

	All adaptations must be made utilizing the most cost-effective materials and supplies. The environmental modification must incorporate reasonable and necessary construction standards. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, water/sewer, foundation, smoke detector systems, roof, free of pest damage) must be in compliance with any applicable local codes.
ACTIVITIES NOT ALLOWED	Excluded are: 1) those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant (carpeting; roof repair; sidewalks; driveways; garages; central air conditioning; hot tubs; whirlpool tubs; swimming pools; landscaping; pest control; converting or updating a cesspool to a septic tank system or an aerobic treatment unit system, or connecting to a new sewer system; and general home repairs and maintenance); 2) cosmetic improvements or upgrades that exceed the most cost-effective materials in the specifications to meet the needs; 3) additional square footage means adding to the home's living area or living space that is considered "habitable space" in the building code. EAA shall not be authorized to build an extension or addition at, above or below grade on the existing structure of living area; convert and/or enclose a garage, shed, carport space, porch, lanai or other non-living space such as attic or area with sloped ceiling that does not meet minimum ceiling height requirements; build an ohana or accessory dwelling unit; 4) adaptations, modifications, improvements or repairs to the existing home where long-term residency of the participant cannot be assured. Long-term residency must be defined as five (5) consecutive years; 5) adaptations, modifications, improvements or repairs to licensed or certified care homes; 6) duplicate adaptations, modifications or improvements regardless of the payment source;

	7) new residential construction (e.g., homes or apartment buildings), even if the new dwelling is designed to be accessible by and/or accommodate the needs of individuals with disabilities; and 8) adaptations, modifications, improvements or repairs exclusively required to meet local building codes. Assessment and training are excluded from this service and are covered under Training and Consultation (T&C).
LIMITS	Adaptations must be of direct medical or remedial benefit and not be considered experimental. "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement. "Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal. Limit of $55,000 per request which includes a maximum of $45,000 for the modification and a maximum of $10,000 for the engineering or architectural drawings and permits required by the city or county where the home is located. Requests for modifications are limited to once in the life expectancy of the modification as follows: a) Grab bars – 5 years b) Environmental Control Devices (automatic door opener) – 5 years c) Exterior ramp – 7 years. Egress is limited to one exterior door. d) Bathroom modification – 15 years e) Widen doors and hallways – 15 years f) Other modifications – determined on a case-by-case basis

	A participant may request more than one modification within a five (5) calendar year period but the requests must be medically necessary to address different needs, such as a ramp for access to the building and a roll-in shower for bathing. Exceptions to these time limits may be made for health and safety of the participant, e.g., participant condition changes and needs a modification in order to remain in the community or the participant must move from a rented setting. Participants are always afforded the ability to request that DOH-DDD review the participant's situation if a modification is needed prior to the life expectancy of the modification period. If the homeowner builds an addition onto the home, EAA may be authorized for the modifications needed to finish the interior of the new space, limited only to those items that meet the participant's accessibility needs. For example, EAA may be used to fund difference in cost between new construction and the adaptation required to install a wider door or accessible shower but shall not be used for the purpose of constructing the addition.
AUTHORIZATION	CM with approval of Unit Supervisor authorizes the EAA services for drawings and permitting not to exceed $10,000 limit. CM with approval of Unit Supervisor and Fiscal Office authorizes the EAA service for construction to complete the EAA not to exceed $45,000 limit once successfully awarded through HIePRO. This is a one-time purchase and the service ends once the participant's environmental accessibility adaptation has been completed and the participant/family and T&C provider have completed training and signed off on the EAA.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	Training and Consultation (T&C) –Environmental Accessibility Adaptation Clinician: The assessment of the need for the EAA is completed by a qualified T&C professional. Assessments for EAA cannot be bundled with an assessment for Specialized Medical Equipment or

	Assistive Technology, which must be authorized separately by the CM. The participant must be offered a choice of providers and can select a different qualified provider for the assessment and/or training needed for the EAA. The T&C professional must not have any conflict of interest with any vendor or business that provides the EAA. The T&C Provider will work with the EAA Provider to ensure that any staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.2, Table 3.2-1) **Building Contractor** (Column H) **Vendor for Permitting** (Column H)	Qualified vendor for construction: Independent Contractor with current and valid license through the State of Hawai'i Department of Commerce & Consumer Affairs as General Contractor and has a State General Excise Tax License. The contractor must provide services in accordance with applicable state, county and city building codes. The contractor must be authorized as a Medicaid provider for EAA once awarded the contract through the State's procurement system. Qualified vendor for drawings and permit application: DOH-DDD Waiver Provider, i.e., agency with Medicaid provider agreement, with at least two years of experience in developing the drawings and completing the permitting process for environmental accessibility adaptation projects.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	There are no additional supervision required once EAA is in use by the participant and training has been completed.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation is maintained in the file of each participant who received the EAA, the participant and others have been trained in its use, and the T&C provider and participant/family have signed off that the service meets the participant's needs.

4.10 - INDIVIDUAL EMPLOYMENT SUPPORTS (IES)

SERVICE DESCRIPTION	Individual Employment Supports (IES) are based on the belief that all individuals with intellectual and developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain access to and maintain employment in the community, but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. IES are designed to maximize the participant's skills, talents, abilities and interests. The goal of IES is employment in a competitive integrated work setting. This is defined as a work place in the community or self-employment, where the participant receives at least minimum wage or the prevailing rate for that work, where the majority of individuals do not have disabilities, and which provides opportunities to interact with non-disabled individuals to the same extent that individuals employed in comparable positions would interact. Services may be ongoing based on the support needs of the participant and must increase individual independence and reduce level of service need. IES consists of **Job Development** and **Job Coaching**.
LOCATION OF SERVICES	Job Development is primarily community-based but may also involve work from the job developer's office in contacting prospective employers. Job Coaching is provided at the participant's place of employment in the community. This service may be delivered via telehealth. See Section 4.1 for details.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	The ratio is one (1) IES staff to one (1) participant.
TRANSPORTATION	Transportation to and from the supported employment activities must be arranged by the participant with assistance by the Provider.

HOURS OF OPERATIONS	Hours of service are flexible, based on needs of participants' jobs and shifts.
REIMBURSABLE ACTIVITIES	IES includes activities needed to obtain and maintain an individual job in competitive or customized employment or self-employment, including home-based self-employment. IES activities includes: 1) ongoing job coaching services to include on-the-job work skills training and systematic instruction required to perform the job with fading of supports as the participant becomes more confident and competent in the job to the extent possible; 2) person-centered employment planning; 3) job development, carving, or customization; 4) negotiations with prospective employers; 5) assistance for self-employment, including: a) identifying potential business opportunities that align with the participant's marketable skills, personal attributes, preferred tasks and ideal workplace conditions; b) identifying natural supports needed in order for the participant to operate the business; c) identifying and connecting the participant to community resources and services for long term support with business planning, feasibility assessments, marketing, accounting, etc.; and d) applying systematic instruction and job coaching that will fade over time for the participant to be independent in completing the job tasks of his/her business. 6) worksite visits as needed by the individual or employer to assess for new needs and to proactively support the participant to address issues that arise (typically at the worksite unless the individual requests visits outside the worksite or worksite visits are deemed too disruptive by the employer); 7) ongoing evaluation of the individual's job performance except for supervisory activities rendered as a normal part of the business setting; training related to acclimating to or acceptance in the workplace environment, such as effective communication with co-workers and supervisors and when and where to take breaks and lunch;

	8) individualized problem-solving/advising with the participant about issues that could affect maintaining employment; 9) training in skills to communicate disability-related work support and accommodation needs; 10) assessing the need for basic job aids, facilitating referral through the participant's CM for assistive technology assessment and acquisition of assistive technology from the Division of Vocational Rehabilitation; 11) facilitating referral through the CM to a Discovery & Career Planning provider for financial literacy, money management and budgeting; 12) providing information and training, as appropriate, for employers related to disability awareness, use of tax credits and other incentives, individual disability-specific training, and use of basic job aids and accommodations (may or may not be delivered with the participant present); 13) training in arranging and using transportation, such as fixed route public transportation or paratransit services to get to and from the participant's place of employment; and 14) career advancement services. Services are typically delivered face-to-face with the participant. Exceptions where the participant may or may not be present include: 1) job development, carving, or customization; 2) negotiations with prospective employers including meetings and phone calls; and 3) discussions with the participant's supervisor or family
ACTIVITIES NOT ALLOWED	IES does not include: 1) supporting the participant to perform work that benefits the waiver provider, regardless of wage paid, including paid employment in an enterprise owned by the provider of IES or a relative of that provider; 2) paying incentives, subsidies or unrelated vocational training expenses such as the following:

	a) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment arrangement; b) payments that are passed through to participants receiving IES; c) payments for training that is not directly related to the participant's IES; 3) paying expenses with starting up or operating a business; 4) supporting the participant to engage in self-employment that is not likely to result in earning at least minimum wage for hours worked within the first year of creating the business; 5) supporting an activity if the activity is a hobby and not a business; 6) providing supervision, bookkeeping or related administrative duties required to operate the participant's business; 7) continuing the service for the sole purpose of providing transportation to and from the place of employment once the participant no longer needs job coaching; and 8) paying for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business. IES services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those services beyond any program limitations.
LIMITS	Personal care/assistance may be a component of IES but does not comprise the entirety of the service. If ongoing personal assistance or supports is needed, the CM may authorize Community Learning Services – Individual (CLS-Ind) services at the workplace. IES (with the exception of job development, negotiations with prospective employers or meetings and phone calls where the participant may not be present, such as discussions with the supervisor or family) may not be provided at the

	same time (same hour) as another face-to-face service, such as Personal Assistance/Habilitation (PAB), Adult Day Health, Community Learning Service, Discovery & Career Planning, or Respite. Job Development activities must be related to the participant's job goal and limited to 80 hours per Plan Year. IES is limited to a maximum of 40 hours per week. For a transition-age student from the age of fourteen (14) years until exiting school, IES may be provided when the student is not engaged in any vocational training and only during non-school hours. Non-school hours are defined as not being delivered during the school day or educational hours as defined in the Individualized Education Plan (IEP) for a student who is attending school, such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the waiver will not provide DCP services during the times when the participant would otherwise be attending school. These limits do not apply once an adult has graduated or exited school. Prior to delivering IES to a minor-aged student, the provider must verify documentation that the student is permitted to work in accordance with Chapter 390, Hawai'i Revised Statutes.
AUTHORIZATION	IES are authorized based on the participant's Individualized Service Plan (ISP) and developed through a detailed person-centered planning process, which includes annual assessment of employment goals.
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	Providers of employment services must have at least one Employment Specialist or Service Supervisor who is a Certified Employment Service Professional. **Employment Specialists** must have the knowledge and competency to deliver quality employment services to assist job seekers with I/DD in acquiring competitive integrated employment.

	An Employment Specialist also acting as a Service Supervisor must have a Bachelor's Degree. Employment Specialists will have specialized training and demonstrated competency in all of the following areas: a) Application of core values and principles in delivery of employment services: rights, history, legislation, best practice and professionalism. b) Individualized assessment and employment/career planning: assess strengths, skills, interests, situational assessment, career exploration, support plan, stakeholder involvement, work impact on benefits, accommodation plan, and transition to work models. c) Community research and job development: knowledge to prepare marketing approaches and materials for job developer and job seeker (brochures, resumes, profiles and materials), planning job seeker involvement and decision making, assistance with disclosure and accommodations requests, networking, development of skills for outreach and interactions with employers to explore their needs, as well as conducting community research including labor market information, range of employers in the area and information on specific employers or industries. d) Workplace and related supports: job analysis, starting the job, implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, ongoing supports and funding, access to resources needed for long-term employment, opportunity for career advancement, transportation planning, and ensuring work is well integrated into life activities and supports. Employment Specialists are required to complete specialized training in implementing the DCP pathway within the first two years of hire. Specialized training may be completed by completing an Association of Community Rehabilitation Educators (ACRE) certified Customized Employment curricula.

	Job Coaches must have the knowledge and competency to provide quality employment services to job seekers with I/DD in maintaining competitive integrated employment. The Job Coach will have specialized training and demonstrated competency in the following areas: a) Application of core values and principles in delivery of employment services: rights, history, legislation, best practices and professionalism. b) Workplace and related supports: implementing support plans, involvement in usual employer training, systematic instruction, natural supports, social inclusion, fading, positive behavioral supports, opportunity for career advancement, and tasks associated with best practices in how to deliver IES. Job Coaches are required to complete training in Customized Employment or other ACRE certified curricula within the first two years of providing job-coaching services.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	The Service Supervisor must complete a customized employment overview that includes the Discovery and Career Planning Pathway, job development, systematic instruction, job coaching, and benefits planning within the first two years of providing employment services.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those programs beyond any program limitations. A Job Coaching Fade Plan must be submitted to the circle of support during the first quarter of job coaching. Systematic Instruction forms must accompany quarterly reports for job coaching services. The provider must report to DOH-DDD on a quarterly basis the following information for each participant receiving IES: participant's name, whether they are receiving job development or job coaching or both,

	hours working per week, rate of pay, place of employment or self-employment, employment start date, employment end date (if applicable), and average number of hours of support provided per week by job developer and/or job coach. Job Development services must document why the business was chosen for the participant.

4.11 - NON-MEDICAL TRANSPORTATION (NMT)

SERVICE DESCRIPTION	Non-Medical Transportation (NMT) enables participants to gain access to waiver services that do not include transportation and other (non-waiver) community services, activities and resources, and support community living as specified in the Individualized Service Plan (ISP). NMT should only be utilized when family, neighbors, friends, or community agencies that can provide transportation without charge are not available. NMT may be provided by staff of a Provider or a Vendor or through the Consumer-Directed (CD) option. NMT may be delivered on a per-trip or per-mile basis.
LOCATION OF SERVICES	Not applicable for this service.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.
TRANSPORTATION	This service covers transportation. Refer to service description, reimbursable activities, limits and activities not allowed for the specific information about this service.
MEALS	Meals are not included in this service.
HOURS OF OPERATION	NMT services are available based on the participant's preferences and needs as identified through the person-centered planning process and documented in the ISP.
REIMBURSABLE ACTIVITIES	NMT may be used by a participant who lives in a rural or other area where public transportation is limited or non-existent; or if the participant requires door-to-door transportation because he/she is unable to reasonably access the bus stop or other public pick-up location. NMT enables participants to gain access to community resources and activities specified in the ISP such as: 1) Community events or activities of the participant's choosing; 2) Work; 3) Volunteer sites; 4) Homes of relatives or friends;

	5) Civic organizations or social clubs; and 6) Public meetings or other civic activities.
ACTIVITIES NOT ALLOWED	NMT must not be used to provide or replace medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable) delivered through the QUEST Integration health plans. NMT may not duplicate transportation that is part of another waiver service: 1) for the purpose of transporting the participant to and from an Adult Day Health (ADH) center; 2) for the purpose of community activities that occur during Community Learning Services (Individual or Group or Consumer-Directed); or 3) for the purpose of Discovery & Career Planning exploration activities in the community. NMT may not duplicate transportation to a setting that is the responsibility of another agency, such as the Department of Education or Division of Vocational Rehabilitation. NMT may not be provided to minor children, less than 18 years of age, by parents, step-parents, or the legal guardian of the minor. NMT may not be provided to a participant by their spouse. An individual serving as a designated representative cannot be a paid provider of NMT through consumer-directed arrangements.
LIMITS	NMT services are limited to intra-island, ground transportation.
AUTHORIZATION	NMT is authorized by the CM based on the ISP.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	Not applicable for this service.
STAFF QUALIFICATION REQUIREMENTS	The Direct Support Worker (DSW), CD employee or Vendor must possess: 1) Valid Hawai‘i driver’s license;

(These are in addition to requirements in Section 3.4)	2) Public Utilities Commission (P.U.C.) license as appropriate; 3) Current automobile insurance (meets or exceeds minimum requirements under Hawai‘i state law).
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	For CD, the employer supervises the employee(s).
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	The Provider or CD employer must maintain a written transportation log which must include, but not be limited to, the following: a) participant name; b) date(s) of service; c) start time and end time of trip(s); d) location(s) where the participant begins travel and each destination point (point to point, not round trip); e) total miles traveled if delivered on a per-mile basis; and f) the name of the DSW or vendor providing the service. The Provider must maintain a file, as appropriate, that contains documentation of: a) licensure with the Public Utilities Commission (PUC) to provide transportation services; b) City and County and State Department of Transportation motor vehicle safety requirements; and c) all other applicable licensing requirements for drivers and vehicles that provide transportation services for participants. The Provider and CD employers must develop emergency protocols and contingency plans that ensure the health and safety of participants. Make copies of the transportation log available to the participant, the participant’s legal or designated representative, and/or the Case Manager, as requested.

4.12 - PERSONAL ASSISTANCE/HABILITATION (PAB)

SERVICE DESCRIPTION	Personal Assistance/Habilitation (PAB) includes a range of assistance or habilitative training services provided primarily in the participant's own home or family home to enable a participant to acquire, retain and/or improve skills related to living in his/her home. Through the person-centered planning process, the participant is afforded the choice and flexibility to decide the skills/activities to work on in the home setting using PAB and the skills/activities to work on in community-based settings using other waiver services. A different service, Community Learning Service, is delivered outside the participant's home and focuses on community-based skill development opportunities. PAB may be provided by staff of a Provider or through the Consumer-Directed (CD) option. PAB is available to participants of all ages. PAB is subject to Electronic Visit Verification (EVV). See Introduction, E. and Section 3.2 for details.
LOCATION OF SERVICES	PAB services are provided in the participant's own home or family home. PAB services may be provided in an acute-care hospital setting (The Provider shall use the Place of Service code, 21).
SERVICE TIERS	This service does not include any tiers.
STAFF TO PARTICIPANT RATIO **Agency**	PAB is typically delivered at a ratio of 1:1 unless specifically authorized in the ISP for small group. Provider agencies provide PAB at a ratio of • 1:1 – one (1) staff to one (1) participant • 1:2 – one (1) staff to two (2) participants • 1:3 – one (1) staff to three (3) participants or at an enhanced staff ratio of

	• 2:1 – two (2) staff to one (1) participant • 3:1 – three (3) staff to one (1) participant A Registered Behavior Technician (RBT) may provide PAB at a 1:1 ratio or an enhanced staff ratio with the following requirements: • Enhanced staff ratios must include a minimum of one RBT • 2:1 or 3:1 – At least one of the staff in each ratio must be a RBT For CD, one CD employee may deliver PAB services at a ratio of: • 1:1 –one (1) employee to one (1) participant, or • 1:2 – one (1) employee to two (2) participants
TRANSPORTATION	Staff travel to and from the participant's home for start of service provision for PAB activities is included in the rate and is not a billable activity. Transportation of the participant is not included in PAB services.
HOURS OF OPERATION	PAB services are available based on the participant's preferences and needs as identified through the person-centered planning process and documented in the ISP. This includes a schedule chosen by the participant to receive PAB during the day, evening, weekends, and holidays.
REIMBURSABLE ACTIVITIES	PAB services are identified through the person-centered planning process and are included in the Individualized Service Plan (ISP) to address measurable outcomes related to the participant's skills in the following areas: 1) Activities of Daily Living (ADL) skills including eating, bathing, dressing, grooming, toileting, personal hygiene and transferring; 2) Instrumental Activities of Daily Living (IADL) including light housework, laundry, meal preparation, arranging public transportation, preparing a grocery or shopping list, using the

	telephone, learning to self-administer medication and budgeting; 3) mobility; 4) communication; and 5) social skills and adaptive behaviors. PAB may be provided through hands-on assistance (actually performing a task for the participant), training (teaching the participant to perform all or part of a task), or multi-step instructional cueing (prompting the participant to perform a task). Such assistance also may include active supervision (readiness to intervene as necessary when there is a greater than 50% likelihood that assistance will be required during the supervision episode). PAB includes personal assistance, which means the direct support worker may perform the care for the participant. However, PAB also includes habilitation, which means the IP must also include strategies for the DSW to implement that teach the participant to acquire, retain or improve a skill for part of the service. Personal care assistance may be a component part of PAB services but may not comprise the entirety of the service. Acquire means to learn a new skill that the participant cannot do. Retain means to keep a skill that the participant already can do. Improve means to get better at a skill the participant can do. PAB services may be provided on an episodic or on a continuing basis. PAB services may be provided in an acute-care hospital setting to foster communication, provide intensive personal care, and/or promote behavioral stabilization to support successful transitions back to the community or to maintain participants' functional abilities.

ACTIVITIES NOT ALLOWED	PAB services may not be provided in a licensed or certified residential home. PAB services may not be provided out of the country. For participants under age 21, PAB may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration (QI) health plans. PAB services may not be delivered during the school day or educational hours as defined in the Individualized Education Plan (IEP) for a student (age 3 to 20) who is attending school, such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the waiver will not provide PAB services during the times when the participant would otherwise be attending school. These limits to not apply once an adult has graduated or exited school. PAB services may not be used to help a student complete Department of Education homework assignments. PAB services may not be used for the sole purpose of child care while parents work outside the home. PAB services may not be provided to minor children, less than 18 years of age, by parents, step-parents, or the legal guardian of the minor. Service provision by family members should not replace "usual non-paid activities and customary" efforts that are typically taught by family members to their children. 1) The family member will provide services in accordance with the Standards of services. 2) The family member will only provide services to the participant for approved services as stated in the ISP and/or Action Plan.

	PAB services may not be provided to a participant by their spouse. An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide PAB. PAB may not be provided at the same time (in the same hour of the day) as Respite, Community Learning Services, Adult Day Health, Discovery and Career Planning, Individual Employment Supports or Residential Habilitation. PAB services provided in an acute-care hospital setting shall not replace services provided by hospital staff and are not a substitute for services the hospital is obligated to provide pursuant to its conditions of participation in Medicare and Medicaid, Federal or State law, or another applicable requirement.
LIMITS	Out-of-state PAB services cannot exceed fourteen (14) calendar days in the participant's plan year for one staff to accompany the participant. An exceptions process is in place for situations that could arise during travel that would require additional authorization of hours. Out-of-state PAB is approved for the same number of hours as the current authorization. If the PAB authorization will be combined with Community Learning Services-Individual (CLS-Ind) while out-of-state, the participant may use only one staff to accompany the participant during the trip. The staff will perform both PAB and CLS-Ind services. The Provider cannot bill for PAB services and PAB Retainer for the same day. Billing for PAB Retainer cannot exceed twenty-four (24) days per calendar year.
AUTHORIZATION	PAB is authorized by the CM based on the ISP. If the participant's request exceeds the Individual Supports Budget amount or service guidelines, the

	participant has the option to request a review through the DOH-DDD exceptions review process. For Provider PAB: The staff to participant ratio for PAB services is 1:1. Requests for enhanced staff authorizations (2:1 or 3:1 ratios) are considered on a case-by-case basis and must be reviewed through the DOH-DDD exceptions review process. Enhanced staff authorizations for Provider PAB (2:1 or 3:1) must be reviewed at regular intervals as specified in the ISP or a minimum every six months to determine the continued need for enhanced staffing. PAB may be authorized at the RBT rate for the hours specified in the ISP that require the RBT to implement the formal behavior support plan developed from the functional behavior assessment. If the RBT is delivering PAB services that do not require implementation of a formal behavior support plan, PAB will be authorized at the regular DSW rate, not the RBT rate. If a participant is admitted into an acute-care hospital setting and the PAB Provider does not provide PAB service, PAB Retainer may be authorized. The PAB Retainer will be calculated based on the average daily authorization and authorized by the CM based on the ISP. The authorization for PAB will be reduced in relation to the authorization for the PAB Retainer. PAB Retainer is not subject to EVV. All claims for PAB Retainer will be subject to post-payment audit.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Professional practicing within the scope of their license and in accordance with Act 205, Session Laws of Hawai'i 2018:* For participants who have a formal behavior support plan (BSP) based on a Functional Behavior Assessment (FBA) that is implemented during PAB

	service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with PAB because the qualified T&C professional will train PAB staff or consumer-directed employees who will implement the BSP. *T&C – Registered Nurse (T&C-RN):* For participants who require nurse-delegated tasks to be completed during PAB service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with PAB because the qualified T&C professional will train PAB staff or CD employees who will perform nurse-delegated tasks. The T&C Provider will work with the PAB Provider and CD employer to ensure staff and CD employees needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the Provider service supervisor's responsibilities or the CD employer's supervision responsibilities. T&C may be delivered concurrently (same 15-minute period) with PAB.*
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	All PAB staff must complete specialized training in community integration. Additional training requirements if the Direct Support Worker (DSW) or Registered Behavior Technician (RBT) will implement a formal behavior support plan or perform nurse-delegated tasks: 1) If the PAB service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the DSW/RBT who provides the service must also complete: a) the DSW must complete specialized face-to-face training that includes, but is not limited to,

	observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) if the worker is an RBT, the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP. c) for either a DSW or RBT implementing a BSP, the staff must also successfully complete a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. 2) If the participant receives an RN assessment that identifies nursing tasks that require delegation during PAB service, the DSW/RBT delivering the service must meet state delegation requirements per HRS 457-2.5 and 457-7. Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.4) **DSW – CD Employee**	The CD employee must be a Direct Support Worker (DSW) who completes the mandatory qualifications: 1) <u>Mandatory</u>: a) Criminal History name check; and b) Satisfactory skills (skill level as defined and identified in the ISP) as verified and documented by the employer prior to the service delivery and in the event of any changes to the ISP, including required training and skills verification for nurse delegated tasks or in implementing a formal Behavior Support Plan (BSP); 2) <u>Recommended</u>:

	In addition, it is recommended that the CD employee complete the recommended qualifications: a) national criminal history checks, Adult Protective Services (APS) and/or Child Welfare Services (CWS) checks according to the Standards set forth by the DHS; b) TB clearance; c) First Aid training; and d) Cardiopulmonary Resuscitation (CPR) training.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	If the service includes implementation of a formal BSP based on an FBA, in addition to General Standards, a) the Service Supervisor must also complete specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/Service Supervisor must complete face-to-face training in the implementation of the BSP. c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain

	RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge. For CD, the employer supervises the employee(s). a) The CD employer must ensure that all CD employees performing nurse-delegated tasks or implementing a formal Behavior Support Plan (BSP) have successfully completed all required training and skills verification.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	1) The Provider or CD employer must maintain a copy of sign-in sheets as documentation of all face-to-face training(s) conducted by the licensed professional or qualified designee for instructing workers in how to implement a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA). 2) The Provider or CD employer must maintain a copy of sign-in sheets as documentation of all skills verification done for nurse-delegated tasks by the Registered Nurse who delegates the tasks.

4.13 - PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

SERVICE DESCRIPTION	PERS is a system that enables waiver participants to maintain safety in the community and secure help in an emergency. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. As part of the system, a participant may also wear a portable "help" button to allow for mobility. The response center may also provide daily reminder calls to participants or respond to other environmentally triggered alarms, e.g., motion detectors, etc., in the household.
LOCATION OF SERVICES	PERS is installed in the participant's own home or family home where the participant resides. Installation in a licensed or certified home is permitted with a transition plan to move within six months.
SERVICE TIERS	Not applicable to this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.
TRANSPORTATION	Not included in this service.
HOURS OF OPERATION	PERS service must be operational 24 hours a day, 7 days a week.
REIMBURSABLE ACTIVITIES	Service includes a one-time installation fee for new systems and ongoing monitoring of the system. PERS providers must: 1) demonstrate and instruct the participant and family in the use of PERS; 2) monitor the PERS by conducting monthly testing of the system; 3) act immediately to repair or replace equipment in the event of a malfunction; 4) provide trained professionals to operate the PERS response center; and 5) have procedures in place for handling electrical power outages and telephone system problems.
ACTIVITIES NOT ALLOWED	Cost of the phone landline is excluded.

LIMITS	This service is available for participants living in their own home or the family home. The installation fee is limited to the rate determined by DHS-MQD and DOH-DDD. Monthly monitoring must not exceed 12 months in the plan year. PERS is not permitted in licensed or certified homes unless there is a plan to move to a more independent living setting within six (6) months and the device is essential to the transition plan as outlined in the ISP. Availability of service may be dependent on the service area of the electronic device.
AUTHORIZATION	New requests for PERS may be authorized by the CM, with approval of Unit Supervisor and Section Supervisor. For existing monthly contracts, PERS is authorized by the CM.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.4)	PERS is provided by a DOH-DDD Waiver Provider, i.e., agency with Medicaid provider agreement. Agency/vendor must have the infrastructure and a minimum of two years of experience performing this specialized service.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	No additional supervision required once PERS is in use by the participant and training has been completed.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation is maintained in the file of each participant receiving this service that the PERS was received, the participant and others have been trained in its use, and the participant/family have signed off that the service meets the participant's needs.

4.14 - PRIVATE DUTY NURSING (PDN)

SERVICE DESCRIPTION	Private Duty Nursing (PDN) services are defined as services determined medically necessary to support an adult (21 years of age and older) with substantial, complex, and continuous nursing and health management support needs. PDN services must be specified in the ISP. PDN services are within the scope of the State's Nurse Practice Act and require the education, continuous assessment, professional judgment, nursing interventions and skilled nursing tasks of a registered nurse (RN), or licensed practical nurse (LPN) who is under the supervision of an RN. The RN and LPN must be licensed to practice in the State of Hawai‘i. PDN services are consistent with the Medicaid I/DD Waiver objectives of avoiding institutionalization. PDN services are provided when all of the following conditions are met: 1) the participant requires continuous but less than 24 hours-per-day nursing care on an ongoing long-term basis; 2) the participant has complex health management support needs for their medical condition based on an assessment; 3) the services have been determined medically necessary when recommended by the treating physician or treating licensed health care provider and approved by DOH-DDD; and 4) the participant requires a nursing care plan that is incorporated into the ISP, which determines the frequency of review for continued need of this service. PDN is subject to Electronic Visit Verification (EVV). See Introduction, E. and Section 3.2 for details. Definitions:

	Substantial means there is a need for consistent nursing assessments and interventions. Interventions not requiring an assessment or judgment by a licensed nurse are not considered substantial. Complex means there is a need for regularly scheduled or more frequent, hands-on nursing interventions. Observation for the purpose of oversight in case a nursing intervention is required is not considered complex and is not covered by the Medicaid I/DD Waiver as medically necessary PDN services. Continuous means there is a need for nursing assessments requiring interventions that are performed at least every two or three hours during the period PDN services are provided.
LOCATION OF SERVICES	Services must be provided in a residential or community setting that ensures the health and safety of the participants. PDN services may be provided in the participant's home or at locations in the community. PDN provided in licensed or certified settings is subject to DOH-DDD review and approval.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	One nurse may provide PDN at a ratio of: 1:1 - one (1) staff to one (1) participant 1:2 - one (1) staff to two (2) participants living in the same home
TRANSPORTATION	Not included in this service. Transportation to medical appointments is covered through the QUEST Integration health plan as medical transportation.
HOURS OF OPERATION	PDN services are available based on the participant's preferences and needs as identified through the person-centered planning process and documented in the ISP.
REIMBURSABLE ACTIVITIES	PDN services must fall within the scope of the State's Nurse Practice Act and be provided by an RN or an LPN who is under the supervision of an RN. PDN activities can only be performed by a nurse and cannot be delegated to a direct support worker. Please refer to examples of non-delegable nursing tasks in Table 1.7-1, Nurse Delegation.
ACTIVITIES NOT ALLOWED	PDN services shall not:

	1) be provided to participants under age 21; 2) duplicate services available to a participant under the Medicaid State Plan, any third-party insurance, a program funded through section 110 of the Rehabilitation Act of 1973, or a program funded through section 602(16) and (17) of the Individuals with Disabilities Education Act (30 U.S.C. 1401 et seq.); 3) be used for respite services or companionship; 4) be authorized when the purpose of having a licensed nurse with the participant is only for observation or monitoring in case an intervention is required where those interventions are not continuous as defined; 5) be used when the nursing care activities can be delegated to qualified direct support workers performing nurse-delegated tasks in accordance with HRS §457-7.5. "Qualified" means the DSW has been trained by the nurse who has determined the DSW can perform the delegated activities; 6) be provided during transportation to and from school or during all instruction activities specified in the Individual Education Plan; or PDN is not provided on an intermittent, part-time or time-limited basis. "Intermittent and part-time" is defined as occurring at irregular intervals, sporadic, and not continuous.
LIMITS	PDN services in the waiver are only provided to individuals age 21 and over. Children under age 21 who are enrolled in Medicaid receive medically necessary nursing services through their QUEST Integration health plan under their Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. PDN services are limited to a maximum of an average of 8 hours per day during the authorization period. PDN services cannot be provided at the same time (same 15-minute period) as another waiver service,

	except when the participant has been assessed to require 2:1 supports based on the results of a functional needs assessment when the participant requires a nurse for health care needs and a second staff performing distinct and separate duties: 1) while also receiving habilitative training in activities of daily living; 2) while also participating in community learning activities; or 3) while also participating in discovery & career planning, individual employment supports or adult day health activities. PDN services are not intended to provide all of the supports a participant requires to live at home. Personal care and assistance may be provided when incidental to the delivery of Private Duty Nursing as necessary to meet the needs of a participant but may not comprise the entirety of the service.
AUTHORIZATION	PDN services must be prior authorized by DOH-DDD. Any request by the participant for PDN hours exceeding the limit of an average of 8 hours per day must be reviewed through the DOH-DDD exceptions review process. Authorization for a new (initial) request for PDN services must be reviewed by the DOH-DDD Case Management Unit Nurse or other DOH-DDD nurse. The initial authorization must be specified in the ISP. Authorizations for PDN services on an ongoing basis must be reviewed by DOH-DDD at a frequency determined by DOH-DDD and specified in the ISP, but no less than annually. If PDN will be delivered by both RNs and LPNs, the Provider must advise the CM of the projected number of hours the RNs will provide and the number of hours the LPNs will provide. The CM must enter the authorization using different code/modifiers for PDN –

	RN and PDN – LPN. Although hours can be adjusted, the Provider is strongly encouraged to project RN and LPN staffing as closely as possible to avoid multiple requests for adjustments to the authorizations during the plan year. DOH-DDD will assess through the DOH-DDD review process whether the participant continues to meet criteria for and can benefit from the waiver or whether intense medical needs requiring more continuous and complex nursing care make them more appropriate for QUEST Integration (QI) services from the health plans.
TIME-LIMITED AUTHORIZATION	If the participant needs a short-term increase above the eight (8) hours-per-day limit, the authorized increase shall not exceed 30 days. The CM must be notified immediately when an exception request is made for a short-term increase in PDN hours above the limit. A participant may be eligible for a short-term increase in PDN service when he or she meets one of the following significant changes in condition or circumstances: 1) has increased medical support needs, such as new trach or technology or recent hospitalization with new treatment orders, to accommodate the transition and the need for training of informal caregivers. This is available only when nursing services through the participant's health plan have been exhausted. Services will generally start at a higher number of PDN hours and be reduced slowly over the course of 30 days; 2) has an acute, temporary change in condition causing increased amount and frequency of nursing interventions; 3) experiences a family emergency or temporary inability of the informal primary caregiver to provide care due to illness or injury. In situations where PDN services have been determined to no longer be medically necessary because the

	participant's needs could be met with a trained worker performing nurse-delegated tasks in accordance with HRS §457-7.5 but the agency has not hired and trained a worker, an exception request must be submitted through the DOH-DDD in an emergency for time-limited coverage while the agency hires and trains a worker.
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	Registered Nurse (RN) in accordance with Hawai'i state law. Licensed Practical Nurse (LPN) in accordance with Hawai'i state law and working under the supervision of a Registered Nurse. PDN services may be provided by a licensed/certified caregiver or a qualified family member who is employed by a Provider. "Qualified" means the caregiver or family member must meets the requirements (is a licensed RN or an LPN who is under the supervision of a RN).
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	On-site supervision of LPNs providing PDN services must be furnished by an RN in accordance with Hawai'i state law. On-site supervision of the LPN by an RN must be conducted monthly or more frequently as indicated in the ISP and/or Action Plan. The RN supervisor must observe and document the observation of the LPN delivering the service as part of the supervision visit. The Registered Nurse (RN) supervisor must be immediately accessible and available to the LPN during PDN hours: 1) Immediately accessible is defined as having phone communication and protocol in place; 2) Immediately available is defined as staff being designated as standby or on-call; and 3) A crisis contingency plan must be in place for the behavioral or medical health needs of the participant.

DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	The nurse provides detailed notes of interventions, judgments and assessments and makes documentation available at the frequency specified in the ISP for the CM and upon request, review by DOH-DDD and DHS-MQD.

4.15 - RESIDENTIAL HABILITATION (ResHab)

SERVICE DESCRIPTION	Residential Habilitation (ResHab) services are individually tailored supports that assist with the acquisition of, retention of, or improvement in skills related to living in the community. These supports include adaptive skill development; assistance with activities of daily living and instrumental activities of daily living; community inclusion; transportation as part of routine and typical household activities, such as doctor's visits, shopping for the household, participating in family functions and community events attended by household members; and social and leisure skill development that assist the participant to reside in the most integrated setting appropriate for his/her needs. ResHab is a service provided in a licensed/certified home setting and the surrounding community. Every residential setting where ResHab services are delivered must provide a home-like environment. The Provider is responsible for ensuring the Individual Plan (IP) is developed based on the ISP and provide oversight and monitoring of the ResHab service consistent with the state and federal requirements.
LOCATION OF SERVICES	ResHab services must be provided in licensed or certified community, residential settings and the surrounding community.
SERVICE TIERS	There are four tiers of ResHab services: ***ResHab tier 1*** - for participants with the least needs (SIS-based levels 1 and 2) ***ResHab tier 2*** – for participants with moderate needs (SIS-based levels 3 and 4) ***ResHab tier 3*** – for participants with the most significant needs (SIS-based levels 5, 6, and 7) ***Therapeutic Living Program (TLP)*** – for participants residing in a setting licensed as a Special Treatment Facility

	The ResHab tier is assigned using the Supports Intensity Scale (SIS)-based level of support needs.
STAFF TO PARTICIPANT RATIO	Although the ResHab payment rates account for specific staffing in addition to the home manager/primary caregiver that varies based on the size of the home and a participant's support needs as measured by the SIS, actual staffing arrangements are at the discretion of the home owner/operator consistent with the ISPs of the home's residents.
TRANSPORTATION	Transportation between the participant's residence and routine and typical household activities in the community is provided as a component of ResHab services and the cost of transportation is included in the rate paid. ResHab caregivers are expected to provide transportation for activities described in the service description.
HOURS OF OPERATION	ResHab services are available based on the participant's preferences and family needs as identified through the person-centered planning process and documented in the ISP. This includes a schedule chosen by the participant and family to receive ResHab services.
REIMBURSABLE ACTIVITIES	ResHab may be provided in licensed/certified homes but does not duplicate services furnished to the participant as other types of habilitation; participants can receive ResHab on the same day as non-residential services. ResHab services may be provided in conjunction with the following waiver services: 1) Adult Day Health 2) Community Learning Service – Individual (CLS-Ind): Prior authorization by DOH-DDD is required if the participant chooses to receive CLS-Ind from any person living in the home 3) Skilled Nursing or Private Duty Nursing (subject to DOH-DDD review) 4) Training and Consultation 5) Waiver Emergency Crisis Mobile Outreach 6) Assistive Technology 7) Specialized Medical Equipment and Supplies (only that exceed requirements of the license or certification of the home) 8) Additional Residential Supports

	9) Discovery and Career Planning 10) Individual Employment Supports ResHab settings are defined in HAR chapters 11-148 (certified DD AFH), 11-89 (DD Dom), 11-100.1 (ARCH/E-ARCH) and 11-98 (STF). ResHab shall be used to cover participants' physical care and training above and beyond the general care and supervision under the State Supplemental Payment/Level of Care (SSP/LOC) for certified residential settings, i.e., Adult Foster Home (AFH), and licensed residential settings, i.e., Developmental Disabilities Domiciliary Home (DD Dom), Adult Residential Care Home (ARCH), Extended Adult Residential Care Home (E-ARCH), and Therapeutic Living Programs (TLP) licensed as Special Treatment Facilities (STF). Personal care/assistance may be a component part of ResHab services but may not comprise the entirety of the service.
ACTIVITIES NOT ALLOWED	ResHab does not include general care and protective oversight and supervision that are required under the home's license or certification requirements. ResHab payments are not made for the cost of room and board or the cost of home maintenance, upkeep or improvement. Separate payments for Chore Services are prohibited since the provision of routine housekeeping, meal preparation and chore activities are integral to and inherent in the provision of ResHab services in licensed and/or certified settings. Payments are not made, directly or indirectly, to members of the participant's immediate family (parent, guardian, spouse, or siblings).
LIMITS	Provider-owned or leased settings must be compliant with the Americans with Disabilities Act (ADA) requirements.

	The ResHab payment rates were designed based on a 344-day billing year (by dividing the annual cost of services by 344 days) to accommodate occasional participant absences. The annual limit for ResHab services is therefore 344 units (days) within the ISP plan year. Once a provider has billed 344 units during the ISP plan year, the provider is considered to be paid in full for the 365-day ISP plan year under the ResHab authorization. If a participant changes to a different ResHab Waiver Provider Agency during the ISP plan year, the 344-day limit will reset so the new provider can bill for the remaining days in the authorization period. This only applies when a participant changes Providers, not if the participant moves to a different ResHab home with the same Provider.
AUTHORIZATION	ResHab is authorized on a per diem (per day) basis by the CM based on the ISP. The level of support needs will be determined through the SIS and the SIS level will inform the ResHab tier authorized in the ISP. The authorized rate for the service tier will be based on the certified/licensed home capacity (i.e. number of beds) of the ResHab setting. The provider must advise the CM of the number of beds at the participant's ResHab home at the time of the participant's ISP. If the participant requests services that exceed the Individual Supports Budget (ISB), the ResHab Provider must document that all ResHab outcomes have been met and/or hours assumed in the applicable ResHab rate model have been delivered to the participant before other base waiver services that will exceed the ISB can be considered through the DOH-DDD exceptions review process. The documentation is only required when there is a request submitted to the DOH-DDD exceptions review process. The documentation must be submitted to the CM within 14 calendar days of the exceptions request.

	If a need for Additional Residential Supports (ARS) is identified through the person-centered planning process, the participant may request ARS. See ARS Section 4.2.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Professional practicing within the scope of their license and in accordance with Act 205, Session Laws of Hawai'i 2018:* For participants who have a formal behavior support plan (BSP) based on a Functional Behavior Assessment (FBA) that is implemented during ResHab service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with ResHab because the qualified T&C professional will train ResHab DSW implementing the BSP. *T&C – Registered Nurse (T&C-RN):* For participants who require nurse-delegated tasks to be completed during ResHab service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with ResHab because the qualified T&C professional will train the ResHab DSW doing nurse-delegated tasks. The T&C Provider will work with the ResHab Provider to ensure that DSWs needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the ResHab Service Supervisor's responsibilities. T&C may be delivered concurrently (same 15-minute period) with ResHab.*
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	Additional training requirements if the staff, licensed/certified caregiver or Registered Behavior Technician (RBT) will implement a formal behavior support plan or perform nurse-delegated tasks: 1) If the ResHab service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the person who provides the service must also complete:

	a. specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b. if the worker is an RBT, the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP. c. comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. 2) If the participant receives an RN assessment that identifies nursing tasks that may be delegated during ResHab service, the person delivering the service must meet state delegation requirements per HRS 457-2.5 and 457-7. Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	If the service includes implementation of a formal BSP based on an FBA, in addition to General Standards, a) the Service Supervisor must also complete specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/Service Supervisor must complete face-to-face training in the implementation of the BSP. c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a

	comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge. The Provider must ensure ResHab services are provided in settings that are compliant (or transitioning to compliance prior to the federal deadline) with the HCBS final settings rule (42 CFR § 441.301(c) (4)) The service supervisor (or a designee) must be available on-call during all hours that participants are in the home. **ResHab TLP**: 1) On-site supervision must be conducted at least weekly or more frequently as specified in the ISP. 2) If the participant receiving ResHab TLP has a plan that includes a formal BSP, the Service Supervisor must have access to a licensed professional or qualified designee in accordance with Hawai‘i state law for behavior analysis.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	**ResHab Tiers 1, 2, or 3:** 1) The Provider or licensed/certified caregiver must maintain a copy of sign-in sheets as documentation of all face-to-face training(s) conducted by the licensed professional or qualified designee for instructing workers in how to implement a formal Behavior Support Plan

	(BSP) based on a Functional Behavior Assessment (FBA). 2) The Provider or licensed/certified caregiver must maintain a copy of sign-in sheets as documentation of all skills verification done for nurse-delegated tasks by the Registered Nurse who delegates the tasks. 3) HCBS Final Rule Modifications to Participant Access: The Provider must ensure compliance with the HCBS final rule (79 FR 2947) and that the staff or licensed/certified caregiver does not restrict, limit, or modify the participant's access to the community. See Section 3.2 for details.

4.16 – RESPITE

SERVICE DESCRIPTION	The goal of Respite services is to support family relationships to sustain the participant living in the family home. Respite services are only provided to participants living in family homes and are furnished on a short-term basis to provide relief to those persons who normally provide uncompensated care for the participant for at least a portion of the day. Respite may be provided by staff of a Provider or through the Consumer-Directed (CD) option. Respite is subject to Electronic Visit Verification (EVV). See Introduction, E. and Section 3.2 for details. If the participant requires nursing assessment, judgment and skilled interventions during Respite, the service may be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is under the supervision of an RN.
LOCATION OF SERVICES	Hourly Respite services can only be provided in a residential or community setting that ensures the health and safety of the participant: 1) participant's own home 2) private residence of a respite care worker 3) community settings Daily Respite services can only be provided in a licensed or certified setting: 1) DD Domiciliary Home 2) DD Adult Foster Home 3) Adult Residential Care Home 4) Expanded Adult Residential Care Home
SERVICE TIERS	This service does not include any tiers.
STAFF TO PARTICIPANT RATIO	Provider agencies provide hourly Respite services at a ratio of: • 1:1 - one (1) staff to one (1) participant • 1:2 - one (1) staff to two (2) participants

	• 1:3 - one (1) staff to three (3) participants For CD, one CD employee may deliver hourly Respite services at a ratio of: • 1:1 - one (1) employee to one participant • 1:2 - one (1) employee to two participants
TRANSPORTATION	Not included in this service.
HOURS OF OPERATION	Respite services are available based on the participant's preferences and family needs as identified through the person-centered planning process and documented in the ISP. This includes a schedule chosen by the participant and family to receive Respite services.
REIMBURSABLE ACTIVITIES	Respite services may include the supervision or provision of assistance to meet participant needs in the following areas: 1) Routine health needs such as nurse delegated tasks; 2) Activities of Daily Living (bathing, toileting, etc.); and 3) Meal preparation. 4) If Respite is provided by an RN or LPN, perform nursing assessment, judgment and skilled interventions that may arise during the Respite service. 5) General supervision, including overnight hours, when the worker is required to be present and responsive to participant needs.
ACTIVITIES NOT ALLOWED	Respite shall not be provided in institutional settings, such as long-term nursing care facilities or intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Respite is not available to participants who reside in licensed or certified settings. Respite provided on an hourly basis may not be delivered during the same time (same 15 minutes) that the following face-to-face services are delivered: Personal Assistance/Habilitation (PAB), Adult Day Health (ADH), Discovery and Career Planning, Individual Employment Supports – Job Coaching, Private Duty Nursing or Community Learning Services (CLS).

	Respite may not be provided to minor children, less than 18 years of age, by parents, step-parents, or the legal guardian of the minor. Respite may not be provided to a participant by their spouse. An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide Respite. Respite services provided by a nurse shall not be authorized to supplement PDN hours on a regular scheduled basis or for participants who do not otherwise receive nursing services as specified in "Limits".
LIMITS	Multiple episodes of respite may occur during the year. However, any episode of respite is limited to 14 consecutive days. The total annual amount of Respite is limited to 760 hours. Daily Respite is limited to licensed or certified residential homes. Hourly Respite with the 15-minute codes is provided in the participant's own home or the private residence of a respite care worker. Participants who receive ongoing nursing services because the participant requires the assessment, judgment, and skilled interventions of a nurse may choose to receive Respite from a qualified respite worker or by an RN or LPN. Ongoing nursing services must be authorized through one of the following: a) for children under age 21, Skilled Nursing or Private Duty Nursing (PDN) provided through QUEST Integration EPSDT services; b) for adults age 21 and older, PDN provided through the 1915(c) I/DD waiver services or Skilled Nursing provided through the QUEST Integration health plans;

	c) for participants with third-party insurance, PDN or Skilled Nursing services through the insurer. Respite services provided by an RN or LPN must be obtained from a Medicaid I/DD Waiver Provider and cannot be consumer-directed. Participants may choose CD to employ respite workers, but cannot use CD to employ nurses.
AUTHORIZATION	Respite is authorized by the CM based on the ISP. If Respite will be delivered by both RNs and LPNs, the Provider must advise the CM of the projected number of hours the RNs will provide and the number of hours the LPNs will provide. The CM must enter the authorization using different code/modifiers for Respite – RN and Respite – LPN. Although hours can be adjusted, the Provider is strongly encouraged to project RN and LPN staffing as closely as possible to avoid multiple requests for adjustments to the authorizations during the plan year. Requests for Respite beyond the annual limit of 760 hours must be submitted through the DOH-DDD exceptions review process. Respite services provided by a nurse must be provided using the 15-minute code only.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	*Training and Consultation (T&C) by Behavior Analyst, Psychologist or Other Professional practicing within the scope of their license and in accordance with Act 205, Session Laws of Hawai'i 2018:* For participants who have a formal behavior support plan (BSP) based on a Functional Behavior Assessment (FBA) that is implemented during Respite service hours, the ISP will specify the amount and frequency of T&C. This is a separate service that interfaces with Respite because the qualified T&C professional will train Respite staff or consumer-directed employees who will implement the BSP. *T&C – Registered Nurse (T&C-RN):*

	For participants who require nurse-delegated tasks to be completed during Respite service hours, the ISP will specify the amount and frequency of T&C-RN. This is a separate service that interfaces with Respite because the qualified T&C professional will train Respite staff or CD employees who will perform nurse-delegated tasks. The T&C Provider will work with the Respite Provider or the CD employer to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services. *NOTE: T&C does not replace the Provider or CD employer Service Supervisor's responsibilities. T&C may be delivered concurrently (same 15-minute period) with Respite.*
STAFF AND LICENSED/CERTIFIED CAREGIVER QUALIFICATION REQUIREMENTS (These are in addition to requirements in Section 3.4)	The Provider must ensure that Respite workers have written information on: 1) basic health and safety needs and care affecting the participant; 2) emergency and personal information; and 3) medical history as outlined in the ISP. Additional training requirements if the staff, licensed/certified caregiver, CD employee or Registered Behavior Technician (RBT) will implement a formal behavior support plan or perform nurse-delegated tasks: 1) If the Respite service includes implementation of a formal Behavior Support Plan (BSP) based on a Functional Behavior Assessment (FBA), the person who provides the service must also complete: a) specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) if the worker is an RBT, the current RBT credential substitutes for the specialized training requirement but the RBT must complete face-to-face training in the implementation of the BSP.

	c) a comprehensive training on Positive Behavior Supports (PBS) and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. 2) If the participant receives an RN assessment that identifies nursing tasks that require delegation during Respite service, the person delivering the service must meet state delegation requirements per HRS 457-2.5 and 457-7. Training(s) for meeting these requirements must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.4) **DSW – Consumer-Directed Employee**	The CD employee must be a Direct Support Worker (DSW) who completes the mandatory qualifications: 1) <u>Mandatory</u>: a) Criminal History name check; and b) Satisfactory skills (skill level as defined and identified in the ISP) as verified and documented by the employer prior to the service delivery and in the event of any changes to the ISP, including required training and skills verification for nurse delegated tasks or in implementing a formal Behavior Support Plan (BSP); 2) <u>Recommended</u>: In addition, it is recommended that the CD employee complete the recommended qualifications: a) national criminal history checks, Adult Protective Services (APS) and/or Child Welfare Services (CWS) checks according to the Standards set forth by the DHS; b) TB clearance; c) First Aid training; and d) Cardiopulmonary Resuscitation (CPR) training.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS	Respite by an RN does not require a Service Supervisor. If the service includes implementation of a formal BSP based on an FBA, in addition to General Standards,

(These are in addition to requirements in Section 3.4)	a) the Service Supervisor must also complete specialized face-to-face training that includes, but is not limited to, observation, behavior interventions, skill acquisition, data collection, documentation and reporting; or b) the Service Supervisor is a Registered Behavior Technician (RBT), the current RBT credential substitutes for the specialized training requirement but the RBT/Service Supervisor must complete face-to-face training in the implementation of the BSP. c) whether the Service Supervisor is qualified under a) or b), the Service Supervisor must complete a comprehensive training on Positive Behavior Supports and an approved behavioral/crisis management system compatible with PBS and in accordance with DOH-DDD P&P #2.01 *Positive Behavior Supports* and #2.02 *Restrictive Interventions*. Training(s) for meeting the requirements of a) and b) must be conducted by a licensed professional or qualified designee in accordance with Hawai‘i state law. It is recommended that the Service Supervisor for a participant’s plan that includes BSP interventions obtain RBT certification. Note that the RBT certification does not permit the Service Supervisor to oversee the BSP; however, the RBT certification demonstrates that the Service Supervisor has a standard base of knowledge. For CD, the employer supervises the employee(s). The CD employer must ensure that all CD employees performing nurse-delegated tasks or implementing a formal Behavior Support Plan (BSP) have successfully completed all required training and skills verification.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	The Provider or CD employer must maintain a copy of sign-in sheets as documentation of all skills verification done for nurse-delegated tasks by the Registered Nurse who delegates the tasks.

	If Respite is provided by LPNs, the agency must assign one RN to oversee the Respite service and be responsible for written quarterly service supervision reports that are submitted to the CM. If Respite is provided by RNs, the RN is responsible for written quarterly reports that are submitted to the CM.

4.17 - SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SMES)

SERVICE DESCRIPTION	Specialized Medical Equipment and Supplies (SMES) includes devices, controls, or appliances, specified in the service plan, which enable participants to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. All items must be ordered by a practitioner with prescriptive authority in accordance with Hawai‘i state law. An order is valid one year from the date it was signed. All items must meet applicable standards of manufacture, design and installation.
LOCATION OF SERVICES	SMES will be used by the participant in locations that are customary to the participant.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.
TRANSPORTATION	Not included in this service.
REIMBURSABLE ACTIVITIES	SMES include: 1) devices, controls, appliances, equipment and supplies, specified in the ISP that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; 2) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; 3) such other durable and non-durable medical equipment not available under the State Plan that are necessary to address participant functional limitations; and 4) necessary medical supplies.
ACTIVITIES NOT ALLOWED	SMES under the waiver may not replace the medical equipment and supplies covered by other insurances or under the State Plan through the QI health plans, including EPSDT medically necessary equipment and supplies for waiver participants under age 21.

	All applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies must be followed. This service may not be used to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using network providers that participate with that program and adhering to prior authorization requirements of that program. SMES exclude those items that are not of direct medical or remedial benefit to the participant or are considered to be experimental. “Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or supply that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement. "Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal. Eye glasses, hearing aids, and dentures are not covered. Assessment and training are excluded from this service and are covered under Training and Consultation (T&C). An assessment from the Department of Education or another program or insurer, completed by a qualified Occupational Therapist (OT), Physical Therapist (PT) or Speech Language Pathologist (SLP), may be used in place of T&C if it is dated within one year of the request for the specialized medical equipment or supply.
LIMITS	There must be documented evidence that the item is the most cost-effective alternative to meet the participant's needs. Nutritional diet supplements, such as Ensure and Pediasure, are only covered by the waiver if the participant can eat by mouth (no feeding tube) and is at risk for weight loss that will adversely impact the participant's health. Prior to

	authorization, the plan includes a request from a medical provider and measurable weight goals and a follow-up plan. Additional diapers, pads and gloves over the amount covered by the State Plan may be covered by the waiver only on a temporary or intermittent basis. Temporary is defined as a period of three months or less. Intermittent is defined as occurring at irregular intervals, sporadic and not continuous.
AUTHORIZATION	SMES is authorized by the CM, with approval of Unit Supervisor and Section Supervisor. This is a one-time purchase and the service ends once the participant has received the specialized medical equipment or supplies and training has been completed.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	Training and Consultation (T&C) – OT, PT, or Speech Language: The assessment of the need for SMES is completed by a qualified T&C professional. Assessments for SMES cannot be bundled with an assessment for Assistive Technology or Environmental Accessibility Adaptations, which must be authorized separately by the CM. The participant must be offered a choice of Providers and can select a different qualified provider for the assessment and/or training needed for the SMES. The T&C professional must not have any conflict of interest with any vendor or business that provides the SMES. The T&C Provider will work with the SMES Provider to ensure that staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.4)	The SMES provider must meet applicable State licensure, registration, and certification requirements. • DOH-DDD Waiver Provider, i.e., agency with Medicaid provider agreement Agency • Medical Supply Company
GENERAL SERVICE SUPERVISOR QUALIFICATIONS	No additional supervision required once equipment or supply is in use by the participant and training has been completed.

(These are in addition to requirements in Section 3.4)	
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) or covered under EPSDT or the State Plan through the QUEST Integration health plans or covered by other insurance. If the equipment or supplies would have been covered but the plan rules were not followed, the equipment or supplies must not be purchased using waiver funds. Documentation is maintained in the file of each participant receiving this service that the equipment or supplies were received, the participant and others have been trained in its use, and the participant/family have signed off that the service meets the participant's needs.

4.18 - TRAINING & CONSULTATION (T&C)

SERVICE DESCRIPTION	Training & Consultation (T&C) services assist unpaid caregivers, paid service supervisors and/or paid direct support workers in implementing participants' goals, objectives and outcomes developed from the person-centered planning process and included in the Individualized Service Plan (ISP). The goals, objectives and outcomes are necessary to improve the participant's independence and inclusion in their community. Unpaid caregivers are defined as any person, family member, neighbor, friend, and co-worker who provide care, training, guidance, or support to a waiver participant without financial gain or payment. T&C activities may be provided by the following types of professionals, or their qualified designees if applicable (see Staff and Licensed/Certified Caregiver Qualification Requirements for details): • Behavior Analyst • Dietitian • Family Counseling – Licensed Social Worker, Marriage and Family Therapist, or Mental Health Counselor • Occupational Therapist (OT) • Physical Therapist (PT) • Psychologist • Registered Nurse (RN) • Speech-Language Pathologist • Environmental Accessibility Adaptation Professional – OT or PT that meets minimum requirements
LOCATION OF SERVICES	This service may be delivered in the participant's home or in the community as described in the ISP. This service may be delivered via telehealth. See Section 4.1 for details.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.

TRANSPORTATION	An inter-island rate may be paid for the face-to-face time that a T&C professional provides to a participant or family on a different Neighbor Island. Documentation must be provided that there is no T&C professional available on the Neighbor Island. Travel costs are included within the rate and are not billed separately.
REIMBURSABLE ACTIVITIES	T&C activities may include, but are not limited to: 1) evaluation, assessment and re-assessment; 2) recommendations to inform the person-centered planning process and the development of goals, objectives and outcomes; 3) development of plans and/or protocols to address identified needs, for example nurse delegation plans; 4) initial and/or ongoing training, teaching and/or technical assistance (examples below); 5) supportive counseling to strengthen families; 6) supervision or monitoring of the participant, caregivers and providers in the implementation of plans; and 7) revisions to plans and protocols, as needed. Training, teaching and/or technical assistance may include but are not limited to: 1. training on implementing plans and/or protocols (e.g., nurse delegation plans and behavior support plans); 2. instruction about treatment regimens and other services included in the ISP and/or Action Plan, 3. training and instruction on use of equipment specified in the service plan, and 4. updates as necessary to safely maintain the participant at home or in the community. All training needs must be identified and included in the ISP and/or Action Plan. T&C is not intended to provide direct services beyond the time specified in the ISP. T&C also includes attendance at ISP meetings if applicable and documentation/report writing.

	T&C may be delivered concurrently (same 15-minute period) with another waiver service during the time in which the T&C professional provides specialized training, monitoring and coaching to paid staff who implement the participant's plan. T&C Behavior: When a participant has a Behavior Support Plan (BSP) developed through another source (e.g., Department of Education, QUEST Integration, and private insurance), T&C may be authorized to develop a BSP to address behaviors that occur in settings where DOH-DDD services are provided only after all other program coverages, such as Early Periodic Screening Diagnostic and Treatment (EPSDT) under the QUEST Integration health plans, have been sought and exhausted. The author of the BSP must ensure consistency among and across the services the participant receives by consulting with the authors of the other BSPs and their treatment teams and utilizing similar interventions in settings where DOH-DDD services are provided, where appropriate. This T&C must include training in implementing the BSP strategies and approaches during waiver service hours, as well as providing periodic monitoring of the BSP to ensure consistency.
ACTIVITIES NOT ALLOWED	T&C services must not duplicate services provided through another source, including Applied Behavior Analysis (ABA) services covered by a participant's commercial insurance or, through EPSDT services under the Medicaid QUEST Integration Health Plan, if the participant is under 21 years of age. T&C services do not supplant any service that is the responsibility of the Medicaid State Plan under the QUEST Integration health plans, another agency or other insurance. T&C services must not duplicate other services under the Medicaid I/DD Waiver, that is, the service may not take the

	place of the provider's supervision of direct support workers as required to be performed by Service Supervisors. T&C services must not be provided to children aged three (3) to twenty (20) years of age as part of, or related to, any educational entitlement services.
LIMITS	T&C is time limited, intermittent, and consultative. • Time-limited means the service is authorized for a specified time period in the ISP. • Intermittent means that the service is delivered at intervals specified by the ISP that generally will be a block of time to complete assessments and training or at ongoing intervals such as ongoing monitoring. • Consultative means the T&C provider delivers services in a manner that trains the workers, family and natural supports to build their capacity to provide the day-to-day supports to the participant. Inter-island T&C is limited to a maximum of four (4) hours of face-to-face time with the participant who lives on a Neighbor Island. It does not include travel time or other activities such as report writing.
AUTHORIZATION	Telehealth as a modality for service delivery is an option for T&C. See Section 4.1 for details. T&C authorizations are specified for each type of service. If T&C will be delivered by both the licensed professional and the qualified designee, if applicable, the appropriate codes/modifiers must be authorized. The T&C provider must advise the CM of the projected number of hours the licensed professional will provide and the number of hours the qualified designee(s) will provide. • Although hours can be adjusted, the Provider is strongly encouraged to project professional and qualified designee staffing hours as closely as possible to avoid multiple requests for adjustments to the authorizations during the plan year. Requests for additional T&C hours must be submitted to DOH-DDD in writing for review, with documentation

	indicating how the previously approved hours were used and what the additional hours are needed for, prior to delivering services exceeding the CM authorization. Initial assessments must be conducted face-to-face with the participant. T&C Behavior Initial authorization: T&C Behavior may be authorized up to five (5) hours by the CM, with approval by the CMU supervisor and CMB section supervisor, for the T&C provider to assist in assessing the need for a formal request for T&C Behavior. In emergency situations, the CM does not need to authorize the five (5) hours before submitting a formal request to the DOH-DDD Clinical Interdisciplinary Team (CIT). Formal request: T&C Behavior for the purpose of completing a Functional Behavior Assessment (FBA), developing a Behavior Support Plan (BSP), and training in implementing the BSP, may be approved up to thirty (30) hours by the DOH-DDD-CIT. Requests must include written justification, data and other pertinent information, and be submitted by the CM to the DOH-DDD-CIT for review and determination. T&C Behavior for purposes such as ongoing monitoring of the implementation of the BSP, retraining, collection and review of relevant data, and updating the BSP as needed, must be requested through the DOH-DDD-CIT. Additional hours may be authorized based on the review of data and/or documentation that demonstrates the need for increased hours. **Hours authorized for ongoing monitoring must not be used by the author of the BSP to complete tasks or other duties that are the responsibility of the Provider's service supervisor.**

	The authorization of hours may include inter-island rates when the qualified T&C professional is not located on the island where the participant resides. The authorization of inter-island hours is limited to the amount of time needed for observation, interview and data collection that can only be done on-site. Interisland hours will not be authorized for the costs and time for travel as these are included in the inter-island rate. T&C professionals are expected to complete the FBA and develop the BSP during regular authorized T&C hours and rates corresponding to the home office, not inter-island rates. T&C Dietitian T&C Dietitian may be authorized up to four (4) hours by the CM, in consultation with the Unit Supervisor, for assessment and development of a written report and recommendations. T&C OT/PT/Speech-Language: T&C OT, PT and Speech may be authorized up to four (4) hours by the CM, in consultation with the Unit Supervisor, for assessment and development of a written report and recommendations. T&C OT, PT and Speech may be authorized for AT or SMES. T&C OT and PT may be authorized for Vehicle Modifications. If the participant received T&C OT, PT, or Speech-Language for AT, SMES, or Vehicle Modifications, the CM may authorize up to two (2) additional hours for re-assessment, training and signing-off that the modification meets the participant's needs. T&C EAA: T&C EAA may be authorized up to twenty (20) hours by the CM, in consultation with the Unit Supervisor, for assessment and development of a written report and recommendations/specifications for the EAA.

	If the T&C provider must travel inter-island to perform the assessment, the CM may authorize a maximum of four (4) hours of inter-island T&C and the remaining hours up to 16 hours of T&C (for a total of 20 hours maximum). When the EAA request is posted to HIePro or bids are solicited per State Procurement Office (SPO) rules, the CM authorizes 20 hours to provide monitoring and oversight during the EAA construction phase to ensure the project is being completed to meet the participant's needs. After completion of the EAA, the CM may authorize up to five (5) additional hours for re-assessment, training and signing-off that the modification meets the participant's needs. If the T&C professional must travel to another island where the participant's home is located, up to three (3) hours of the five (5) hour maximum follow-up authorization may be authorized at the inter-island rate. Any requests to exceed the authorizations must be submitted in writing from the T&C provider with justification of the need for additional hours due to the complexity of the project and/or unforeseen circumstances beyond the control of the T&C provider, as well as documentation indicating what the previously approved hours were used for. The written justification and request must be submitted to the CM and will be reviewed by the CM Unit Supervisor and CM Section Supervisor. <u>T&C Family Counseling</u>: T&C Family Counseling may be authorized up to five (5) hours by the CM, in consultation with the Unit Supervisor, for assessment of the family's needs. An additional 24 hours (12 two-hour visits) may be authorized for the purposes of enhancing the family's coping skills and problem-solving to reduce family stress, strengthen family capabilities, identifying supports and resources, teaching strategies for reducing risk, and

	counseling to increase family cohesion and family unity. The T&C provider will use evidenced-based practices. T&C RN: T&C RN may be authorized, annually, up to two (2) hours by the CM for a Nursing Assessment. Additional T&C RN may be authorized for a new Nursing Assessment or re-assessment that may be needed due to significant changes in a participant's condition. The hours recommended in the Nursing Assessment will be reviewed by the DOH-DDD. T&C RN will be authorized by the CM, in consultation with the Unit RN, Supervisor, and DOH-DDD-CIT, if applicable.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.4, Table 3.4-1)	In addition to General Standards, the T&C provider must be a licensed professional in accordance with Hawai'i state law and possess the experience necessary to deliver the appropriate service within the scope of their practice. 1) Behavior Analyst: HAR Chapter 465D a. Qualified designees must be explicitly listed in the exemptions of their respective licensure law, supervised by a licensed professional, and can only perform duties as permitted by Hawai'i state law. b. Assessments and service contact notes completed by qualified designees must be co-signed by the supervising licensed behavior analyst. 2) Dietitian: HRS Chapter 448B; 3) Family Counseling: a. Licensed Clinical Social Worker: HRS Chapter 467E b. Licensed Marriage & Family Therapist: HRS Chapter 451J c. Licensed Mental Health Counselor: HRS Chapter 453D 4) Occupational Therapist: HRS §457G; 5) Physical Therapist: HRS Chapter 461J; 6) Psychologist: HRS Chapter 465 a. Qualified designees must be explicitly listed in the exemptions of their respective licensure law,

	supervised by a licensed professional, and can only perform duties as permitted by Hawai‘i state law. b. Assessments and service contact notes completed by qualified designees must be co-signed by the supervising licensed psychologist. 7) Registered Nurse: HRS Chapter 457 8) Speech-Language Pathologist: HRS Chapter 468E 9) Environmental Accessibility Adaptation Professional: must be an Occupational Therapist or Physical Therapist and have a minimum of five (5) years completing EAA assessments or possess specialized certification (Certified Aging-In-Place Specialist – CAPS; Executive Certificate in Home Modification – ECHM; or Certified Environmental Access Consultant – CEAC) All Providers of T&C services must meet the requirements of their respective licensing board and maintain licensing and continuing education documentation. This documentation must be available for review by DOH-DDD upon request.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	Supervision of designees, as applicable, must be in accordance with Hawai‘i state law. <u>T&C Behavior</u>: T&C for behavior support plans implemented by an RBT: The RBT must be supervised by a Licensed Behavior Analyst (LBA) that is a Board-Certified Behavior Analyst (BCBA) or by a Board-Certified Assistant Behavior Analyst (BCaBA) under the supervision of the BCBA. T&C for behavior support plans implemented by a DSW: The DSW can be supervised by a LBA or qualified designee, Psychologist or Other Licensed Professional delivering T&C for behavior supports in accordance with Act 205, Session Laws of Hawai‘i 2018.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation of services must include evaluation, assessments, written plans and/or protocols, reports, documentation of trainings and skills verification, if applicable, and consultation notes.

	All documentation must be maintained in the T&C Provider's records and be available for review by DOH-DDD and/or DHS-MQD upon request. T&C Behavior: 1) Upon completion of the FBA, the BSP must be developed and written within 14 business days and must include the date the BSP report was completed as well as the name of the author and his/her credentials. A final copy of the BSP report must be forwarded by the author to the CM within two (2) business days of the date of completion indicated on the BSP report. See Policy #2.02, Restrictive Interventions, for additional BSP requirements. 2) If a restrictive intervention is proposed for use in a BSP, the intervention must be the least restrictive method to address the challenging behavior (P&P #2.01 Positive Behavior Supports and #2.02 Restrictive Interventions). The restrictive intervention must only be used to prevent imminent risk of harm to the participant or others and should be removed once the imminent risk is no longer present. 3) Training must be initiated by the author of the BSP within seven (7) business days of the completion date indicated on the BSP. Training must include face-to-face instruction of the interventions and data collection methods included in the BSP for all individuals in the participant's circle of support who will implement the BSP. 4) Any variance from these timelines must be requested in writing and must be granted by the CM. 5) A service note must be completed for each contact with the participant. If the service note was completed by the qualified designee, the note must be co-signed by the supervising licensed professional. 6) The licensed professional must document the ongoing supervision for qualified designees. 7) Documentation of challenging behavior(s), including the effectiveness of the recommendations and/or interventions indicated in the BSP, must be reported by

	the provider to the CM every quarter or more frequently, as documented in the ISP. Requests for additional hours of T&C Behavior must be submitted in writing and provide a detailed description of how the additional hours will be used each month to improve the implementation of the BSP and/or collection of data. <u>T&C Dietitian/OT/PT/Speech-Language</u>: 1) Complete comprehensive assessment that identifies, at a minimum, strengths, abilities, interests, needs, and recommendations. 2) Any requests for additional hours of T&C must be submitted in writing. The request must include a description of how the additional hours will be used and why the additional hours are needed. 3) Written assessment must be submitted to the CM within fourteen (14) business days after referral is accepted by the provider unless an extension is requested in writing and granted by the CM. <u>T&C EAA</u> 1) Complete comprehensive assessment that addresses participant and family strengths, abilities, needs and recommendations; 2) Develop specifications for EAA construction project; 3) Provide weekly or more frequent brief written updates with CM during monitoring phase of project to update on participant's health and safety and project status to meet participant's accessibility needs; and 4) Complete post-EAA assessment and training for family and participant. 5) The post-EAA assessment must be signed by the T&C provider and the participant or family member. A copy of the completed and signed assessment must be submitted to DOH-DDD. Assessments for EAA may take several weeks to complete depending on family and participant availability, complexity of project and other variables. The timeline for completing

	the assessment is determined on an individual basis by the DOH-DDD in consultation with the T&C provider. T&C Family Counseling: 1) complete an assessment with the family; 2) develop a plan for supportive counseling; 3) meet face-to-face, in the home (or other location that the family member chooses) with family members; and 4) write summary notes and develop follow-up plan for family. T&C RN: Providers must use the Provider Nurse Delegation Packet to complete the Nursing Assessment (see Appendix 4E). Nursing Assessment: The Nursing Assessment must include, but is not limited to the following: 1) identification of tasks that may be delegated, based on the participant's needs and circumstance, 2) assessment of the participant's circumstance, 3) assessment of the person(s) that may perform the delegated task(s), 4) supervision/monitoring requirements, and 5) recommendation for hours needed to complete nurse delegation requirements (recommended hours will be reviewed and considered for authorization by the DOH-DDD). If the RN determines that any person is unable to perform the task(s) and the RN will not delegate; or that any task is not delegable and must be performed by a licensed nurse, the RN must submit documentation of the written notification with reason(s) to the CM. The Nursing Assessment must be completed annually within fifteen (15) calendar days of the start date of the service authorization, unless otherwise specified in the ISP. Nurse Delegation Plan:

	Nurse delegation must be in accordance with HRS §457-7.5. A Registered Nurse (RN), who is licensed in the state of Hawai‘i in accordance with HRS §457-2.5 and §457-7, must develop the nurse delegation plan for each task and each person performing delegated tasks, at least annually. Nurse Delegation plans must be signed by the delegating RN and each delegatee completing the task. A Licensed Practical Nurse (LPN) shall not develop a delegation plan. The Nurse Delegation plan must: 1) identify the nursing task to be delegated; 2) list the equipment needed; 3) describe each step needed to complete the task; 4) review the expected outcomes of the task; 5) review the possible adverse reaction(s) to the task; 6) specify a clear emergency plan that includes: a. who to call with the phone number and backup phone numbers b. when to initiate Emergency Medical Service (EMS), call 911 7) document the task and observations noted. <u>Nurse Delegation Plan for Medication Administration or Assistance:</u> The nurse delegation plan must include the following for each medication: 1) Brand or generic (as applicable) name, 2) Identifying photo (if available), 3) Intended purpose, 4) Potential adverse effects, 5) Drug/food interactions, 6) General information on recommended dosages and the medication’s effect, and 7) Instructions for monitoring the participant’s response to the medication. Copies of signed Nurse Delegation plan(s) must be in the participant’s record at the service site; including Nurse Delegation plan(s) for any medication assistance or

	administration tasks performed during the waiver service hours with the exception of self-administered medications as defined in Section 1.7. Training and Skills Verification Requirements Training and skills verification on the Nurse Delegation Plan(s) must be performed prior to the start and at least annually thereafter for each delegatee performing nurse delegated tasks. Documentation of training and skills verification must include the delegatee's name(s), date(s) training and skills verification was completed, and the nurse delegated task(s) to be performed. A copy of the signed and completed Nurse Delegation Plan(s) must be sent to the CM within fifteen (15) calendar days of completion of the training and skills verification. Oversight and Monitoring of Nurse Delegation The T&C RN must conduct, at a minimum, quarterly face-to-face visits with the participant and delegate(s) and other supervision/monitoring activities needed, based on the Nursing Assessment. Quarterly, or more frequent, visits must include, but is not limited to: 1) review of the data to determine whether the delegate(s) are performing tasks in accordance with the Nurse Delegation plan(s), for example, reviewing the Medication Administration Record (MAR) and other documents may identify medication errors that need the T&C RN to address with the delegatee; 2) identification of any issues or concerns and recommendations for addressing; 3) discuss any new delegatee training or re-training; and 4) other requirements specified in the ISP.

	Quarterly, or more frequent, visits must be documented, including the date, start and end time, who was present and specific nurse delegated tasks observed. A written quarterly report must be provide to the CM within thirty (30) calendar days of the end of the quarter. All documentation must be maintained in the T&C Provider's file.

Table 4.18-1 LICENSED BEHAVIOR ANALYST RESPONSIBILITIES

ASSESSMENT AND DEVELOPMENT OF PLAN	SUPERVISION	FREQUENCY OF SUPERVISION	DOCUMENTATION	AUTHORIZATION OF DESIGNEE HOURS
Licensed Behavior Analyst (LBA) Board Certified Behavior Analyst (BCBA and BCBA-D) with current Hawaii license ▪ Can complete all assessments ▪ Can develop behavior support plan	**LBA** ▪ Can supervise all ▪ Must meet BACB Supervision Requirements	**Designee Type 1** must be supervised at the frequency in accordance with BACB requirements. https://www.bacb.com/wp-content/uploads/2022/01/BCBA Handbook_220110.pdf	**LBA** must complete a service note for each contact	**LBA** is responsible to determine within the overall authorization for T&C – Behavior Support the percentage of hours will be done by the Designee Type 1 or 2 and percentage of hours by the LBA.
Designee Type 1: Board Certified Assistant Behavior Analyst (BCaBA) or Board Certified Behavior Analyst (BCBA) without current Hawaii license ▪ Requires supervision by LBA ▪ Assessments and behavior support plans must be co-signed by supervising LBA	**Designee Type 1** ▪ Limited - Can supervise RBT & DSW ▪ Works under supervision of the LBA	**Designee Type 2** must be supervised 5% of the hours of service delivery in accordance with BACB requirements	**Designee Type 1** and **Designee Type 2** must complete a service note for each contact. ▪ All documentation must be co-signed by supervising LBA	N/A

ASSESSMENT AND DEVELOPMENT OF PLAN	SUPERVISION	FREQUENCY OF SUPERVISION	DOCUMENTATION	AUTHORIZATION OF DESIGNEE HOURS
Designee Type 2: Trainee An individual pursuing experience in applied behavior analysis consistent with the Behavior Analyst Certification Board's (BACB) experience requirements; provided that the experience is supervised by a licensed behavior analyst ▪ Requires supervision by LBA ▪ Assessments and behavior support plans must be co-signed by supervising LBA	**Designee Type 2** ▪ Limited - Can supervise DSW only. Cannot supervise RBT ▪ Works under supervision of the LBA	**Registered Behavior Technician (RBT)** must be supervised at 5% minimum in accordance with BACB requirements. https://www.bacb.com/wp-content/uploads/2022/01/RBTHandbook_220112.pdf LBA to determine what portion of the program is behavior analytics programming, then discretion re: the amount/frequency (esp. if multiple staffing, or high hours authorized), with at least 2 supervisory contacts, minimum of 1 must be on-site, face-to-face.	RBT and DSW must complete data collection per behavior support plan	N/A
N/A	N/A	**Direct Support Worker** ▪ must be supervised at frequency determined	N/A	N/A

ASSESSMENT AND DEVELOPMENT OF PLAN	SUPERVISION	FREQUENCY OF SUPERVISION	DOCUMENTATION	AUTHORIZATION OF DESIGNEE HOURS
		by LBA for the portion of the program delivering behavior analytics programming, then discretion re: the amount/frequency (esp. if multiple staffing, or high hours authorized), with at least 2 supervisory contacts, minimum of 1 must be on-site, face-to-face. ▪ Frequency of supervision subject to review by DOH-DDD ▪ Waiver services that DSW may deliver with behavior support plan include Personal Assistance/ Habilitation (PAB), Community Learning Services		

ASSESSMENT AND DEVELOPMENT OF PLAN	SUPERVISION	FREQUENCY OF SUPERVISION	DOCUMENTATION	AUTHORIZATION OF DESIGNEE HOURS
		(CLS), Adult Day Health (ADH) and Additional Residential Supports		

4.19 - VEHICLE MODIFICATIONS

SERVICE DESCRIPTION	Adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified in the ISP as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The participant or family must document that the vehicle is owned by the family or participant or if purchasing new, is pre-qualified for financing the vehicle. All items must be ordered by a practitioner with prescriptive authority in accordance with Hawai‘i state law. An order is valid one year from the date it was signed.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	Not applicable for this service.
TRANSPORTATION	Not included in this service.
REIMBURSABLE ACTIVITIES	Modifications include adaptations to the vehicle to enable the participant to safely enter/exit the vehicle, as well as passive vehicle restraint devices such as wheelchair tie-downs. The cost for a new vehicle modification conversion system will include the purchase of an extended warranty that covers repairs to the new conversion beyond the standard warranty for the 4th through 7th year after purchase. Waiver funds may be used to cover the deductible for extended warranty repairs to the conversion. Repairs to the conversion components of the vehicle such as the lift, tie-down or auto-docking system may be covered with documentation that the repair is the most cost-effective solution when compared with replacement or purchase of a new modification. The ISP must document that the repair will ensure that the vehicle modification continues to be the most cost-effective, safe and appropriate way to meet the participant’s accessibility needs. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The cost of assessment and training in use of the modification is included in the service.

ACTIVITIES NOT ALLOWED	The following are specifically excluded: 1) adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual; 2) purchase or lease of a vehicle; 3) maintenance and repairs of a vehicle except maintenance and repairs of the modification; 4) modifications to vehicles that are older than five (5) years or that have more than 50,000 miles; 5) modifications to vehicles with frame or flood damage that have been determined from inspection to be ineligible for modification; and 6) modifications that are for the convenience of the caregiver/driver and are not used by the participant, such as automatic door openers and automatic starters. Assessment and training are excluded from this service and covered under Training and Consultation (T&C).
LIMITS	Modifications for a new conversion system are limited to one request every seven (7) years at a maximum cost of $36,000, inclusive of any shipping costs. The seven (7) years is counted from the date of delivery of the previous new vehicle modification for a conversion system. Requests beyond the maximum cost of $36,000, inclusive of any shipping costs, must be submitted through the DOH-DDD exceptions review process. The cost of the vehicle modification may include shipping to and from another state for a vehicle purchased or owned in Hawai‘i with documentation that the modification cannot be completed within the state. If purchasing a new vehicle, the participant and family must consider purchasing the vehicle on the mainland so only one-way shipping is needed. One-way shipping costs will be separated and the waiver funds are only permitted for the portion of costs attributed to the conversion portion of the total shipping costs. Shipping costs for the vehicle portion are the responsibility of the participant and family.

	All vehicles considered for modification must be less than five (5) years old, have less than 50,000 miles, and have no reported accidents that damaged the frame or flood damage per CARFAX. All vehicles must be inspected prior to shipment to the mainland for modifications. The participant and family buying a vehicle must purchase an extended warranty for the vehicle as a requirement for authorizing the vehicle modification because the conversion warranty can only be purchased with the vehicle extended warranty. If the participant and family have not purchased a new conversion with waiver funds within the past seven years, the vehicle's ramp or lift system and/or wheelchair tie-down or docking system may be repaired one time within seven years at a maximum total cost of $10,000.00.
AUTHORIZATION	The CM, with approval of Unit Supervisor and Section Supervisor, authorizes the Vehicle Modification service. Requests beyond the maximum cost of $36,000, inclusive of any shipping costs, must be submitted through the DOH-DDD exceptions review process. One-way shipping will be authorized unless the participant and family present documentation why the vehicle could not be purchased on the mainland and requires two-way shipping. This is a one-time purchase and the service ends once the participant has received the Vehicle Modification and training has been completed.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	Training and Consultation (T&C) – Occupational Therapist (OT) or Physical Therapist (PT): The assessment of the need for the Vehicle Modification is completed by a qualified T&C professional. Assessments for Vehicle Modifications cannot be bundled with an assessment for Specialized Medical Equipment or Assistive Technology, which must be authorized separately by the CM. The participant must be offered a choice of providers and can select a different

	qualified provider for the assessment and/or training needed for the Vehicle Modifications. The T&C professional must not have any conflict of interest with any vendor or business that provides the Vehicle Modification. The T&C Provider will work with the Vehicle Modification Provider to ensure that any staff needing training, skills verification or other contacts are available when needed for efficient and effective use of T&C services.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards, See Section 3.2, Table 3.2-1)	Vendor with Medicaid Provider Agreement, a minimum of two years of experience performing vehicle modifications and meets the following requirements: 1) Meet applicable State licensure, registration, and certification requirements (be authorized by the manufacturer to sell, install, and/or repair equipment); 2) Ensure that all items meet applicable standards for manufacture, design, and installation; and 3) A licensed Warranty Provider for all the vehicle modifications.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to requirements in Section 3.4)	Training in the use of the Vehicle Modification is completed by the T&C authorized provider. The vendor that modified the vehicle must be on-site during the training as part of the Vehicle Modification service. No additional supervision is required once the Vehicle Modification is in use by the participant and training has been completed.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or covered by other insurance. If the Vehicle Modification would have been covered but the plan rules were not followed, the device must not be purchased using waiver funds. Documentation maintained in the participant's file must include the date the Vehicle Modification was received, date(s) and names of the participant, family and/or staff who were trained in its use, and the participant/family sign-off that the service meets the participant's needs.

4.20.1 - WAIVER EMERGENCY SERVICES – CRISIS MOBILE OUTREACH (CMO)

SERVICE DESCRIPTION	Crisis Mobile Outreach (CMO) services include the initial call requesting outreach and the immediate, face-to-face, on-site crisis support to participants and families experiencing an active crisis which is impacting the participant's ability to function within their family, living situation, and/or community environments. Active crisis includes situations in which the participant exhibits behaviors of such intensity, duration, and frequency that it endangers his/her safety or the safety of others. Without CMO services, the participant may experience hardship due to placement disruption and incarceration and/or the utilization of hospital services. The CMO must be deployed to provide immediate face-to-face, on-site response and supports when the Provider has triaged the call and determined an active crisis exists. CMO is available to waiver participants of any age. The Provider must accept all referrals from DOH-DDD. Services are based on the ISP and/or Action Plan from the CM, if available.
LOCATION OF SERVICES	CMO services must be delivered at the residential or community setting where the participant is located.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	The CMO service supervisor determines the number of CMO staff to deploy based upon the participant's needs and the situation.
TRANSPORTATION	Transportation to and from the participant's location is reimbursable.
HOURS OF OPERATION	Crisis Mobile Outreach must be available 24 hours a day, seven (7) days a week, including holidays.
REIMBURSABLE ACTIVITIES	The outreach service must be face-to-face with the participant for more than fifty percent (50%) of the time of the visit.

	The Provider must provide CMO services that include, but are not limited to, the following interventions to deescalate crisis situations: 1) Telephone consultation through Crisis Telephone Hotline (CTH) with the family, caregiver, or program staff for advice on how best to manage the situation and that results in mobilization. 2) Staff being mobilized must receive information from Crisis Telephone Hotline (CTH) and prepare for mobilization. 3) Travel to and from location. 4) Initial risk assessment. 5) Build rapport. 6) Assess for language interpreter. 7) Assess for need for medical or psychiatric consults. On-call medical consultation staff must be a registered nurse, physician or psychiatrist with a valid license to practice in the State of Hawai‘i. 8) Coordinate with other agencies, such as police or emergency personnel. CMO services must be coordinated with emergency services, police, and OHS and CTH as appropriate. The CMO Provider is responsible to contact the participant’s CM to provide information concerning the services provided and coordinate appropriate follow-up services within the next business day of occurrence. 9) Conduct an overall assessment of the participant, situation and environment. 10) Create a plan for services to implement with the participant and circle of supports. 11) Provide support, problem solving, and conflict resolution, or recommend interventions in a brief solution-focused therapeutic style. 12) Provide a personalized plan moving forward, which could include a safety plan, appropriate information, referral and a contact number for future consultation and follow-up. Review Positive Behavior Plan (PBS) to determine effectiveness and, if appropriate, recommend necessary follow-up action as the result of the Emergency Outreach.

	1) Consult with supervisor to provide a referral to the licensed setting for Out-of-Home Stabilization (OHS) services [formerly called the Crisis Shelter] if necessary. 2) Provide information, assessment and observations to help support intake process into the OHS setting; 3) Complete arrangements, including transportation, for more intensive services, such as OHS or hospitalization, in the event the CMO services are not sufficient to stabilize; 4) Provide additional staffing if needed to stabilize situation and/or transport participant to the licensed setting for OHS services, hospital, or other location. The Provider must design and facilitate a standardized script/protocol to: 1) Follow a standard protocol for assessment, and it must include, but not be limited to, the following information: a) Name(s) of all people involved in the crisis situation, including the participant; b) Address and description of current living situation; c) Cultural and language considerations; d) Risk of harm to self or others; e) Abuse and neglect; f) Trauma; g) Need for emergency services (police or ambulance); h) Description of the crisis situation including people involved, source of stress, behaviors of concern, onset and duration of crisis; i) Treatment history and if there is a current Behavior Support Plan (BSP), if BSP is currently being utilized; j) Co-occurring mental health issues; k) Medical issues and allergies; l) Medications, type, regimen and current and historical compliance with medication regimen; m) Ongoing needs; n) Environmental stressors;

	o) Life/transition stressors; and p) Strengths and vulnerabilities of the participant. 2) Arrive at the participant's location within 45 minutes of dispatch. Exceptions are made for the counties of Hawai'i, Maui, and Kauai due to geographic remoteness and for City and County of Honolulu (island of Oahu) due to traffic delays caused by unforeseen circumstances. All exceptions for time exceeding 45-minute requirement must be documented in progress notes and submitted to DOH-DDD with quarterly reports of performance. 3) If a referral to a licensed setting for OHS services is necessary, utilize a protocol to discern the need based on current risk of harm, the ability to de-escalate the situation in person and the potential for future risk of harm. All referrals for OHS services will, at a minimum, require notification of a supervisor with the option of supervisor approval as a protocol. 4) Follow up with the participant who was in crisis and/or family members or caregivers to assess if further assistance is needed within 36 hours of initial face-to-face contact. "Stabilized in place" is defined as the participant has had no further crisis situations, police contact or hospital visits between CMO and follow-up call. 5) Contact CM to provide update and give a report by phone by the next business day of the occurrence with information from Crisis Telephone Hotline (CTH) staff by the next business day. Confirm from the CM the participant's waiver enrollment status. MANDATORY REPORTING: 1) Any suspected case of physical abuse, psychological abuse, sexual abuse, financial exploitation, caregiver neglect, or self-neglect of a participant who is a dependent adult must be reported by the provider to Adult Protective Services and to the CM immediately upon discovery.

	2) Any suspected case of child abuse or neglect of a participant who is under the age of 18 years old must be reported by the provider to Child Welfare Services, and to the CM immediately upon discovery.
ACTIVITIES NOT ALLOWED	This service may not be billed if there was no face-to-face activity with the participant.
LIMITS	There are no limits to the number of times a participant receives CMO; however, frequent use of this service requires additional follow-up to address the underlying issues causing use of CMO. Short-term time-limited (up to two hours) follow-up monitoring of the participant and situation for stability immediately after the crisis.
AUTHORIZATION	CMO referrals are authorized through the Crisis Telephone Hotline (CTH) screening process. Any referral to a level of care beyond the licensed setting for OHS services, such as hospitalization for medical or psychological reasons must be authorized by a CMO supervisor and medical consultation staff.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standard Section 3.4)	CMO staff providing services to participants and their circles of support must have the following qualifications: 1) a bachelor's degree, at minimum, in social services, psychology, human development, family sciences, or other related degree, and 2) at least one-and-a-half (1.5) years of experience working with people with I/DD and/or behavioral crisis. CMO staff must also have the following specialized training and competencies: 1) Prior to providing services, all staff must receive at least 24 hours of orientation training which covers the following topics: crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources. 2) The Provider must provide documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention treatment protocols as guided by the provider's training curriculum, and I/DD-

	specific situations. Training must promote evidence-based services and best practice procedures for urgent and emergent care situations. 3) Training for staff must include but not be limited to the following topics: a) Person Centered Planning; b) Familiarity with DOH-DDD and mental health service array and other community resources and services to provide guidance and referrals to callers; c) Risk Assessment including suicide, homicide, and any other risk of harm to self or others; d) Screening, assessment, and intervention/treatment planning; e) Positive behavioral support; f) Functional behavioral assessment and behavioral support plan functions and processes; g) Behavioral crisis intervention system (Safety Care, Crisis Prevention Institute (CPI), the Mandt system); h) Dual diagnosis (I/DD and mental health); i) A familiarity with psychotropic medications, classifications and side effects; j) Trauma informed care; k) De-escalation techniques; and l) Cultural and diversity awareness and sensitivity. 4) All staff must show competency in the following areas: a) Following the guidelines of the Standards and their own organization; b) Showing empathy, concern and caring for all participants receiving services; c) Being able to direct and facilitate an effective interaction and avoid power struggles; d) Working with supervisors and other team members to make decisions and provide services; e) Offering choices versus directives; f) Interacting with individuals with intellectual and developmental disabilities and communication deficits; g) Ability to interact with people who are escalated, emotional, anxious, and angry;

	h) Knowledge of how and when to utilize problem solving, alternative choices, and prescribing steps moving forward; and i) Knowledge of how to recognize and act upon a life-or-death situation.
GENERAL SERVICE SUPERVISOR QUALIFICATIONS (These are in addition to General Standards Section 3.4) **Service Supervisor** (Column A)	Service Supervisors must have all of the following qualifications: 1) A master's degree, at minimum, in psychology, social work, or related field; 2) Possess a valid license to practice in the State of Hawai'i as a licensed clinical social worker ("LCSW"), licensed mental health counselor ("LMHC"), licensed marriage and family therapist ("LMFT"), licensed psychologist ("LP"), or registered nurse ("RN"); 3) At least three (3) years of experience working with people in crisis and/or people with I/DD with acute behaviors; 4) The service supervisor must be certified to train staff in the provider's crisis intervention system; and 5) The service supervisor must be able demonstrate to proficiency the ability to train staff on the BSP, if applicable and following training from the licensed professional or qualified designee in accordance with Hawai'i state law. A supervisor must be on call 24 hours a day, seven (7) days a week, in the event of clinically complex or psychiatric-related situations in need of consultation, and a supervisor must be available for on-call service, consultation, direction, and case debriefings. FREQUENCY OF SUPERVISION: 1) Staff must meet with their supervisor individually no less than once a month, and must be a part of clinical team meetings held monthly. 2) Debriefings following the use of restrictive interventions must occur with the supervisor and staff involved within twenty-four (24) hours of the event.

DOCUMENTATION STANDARDS (in addition to General Standards in Section 2.4.B)	Required documentation for each dispatched CMO must include, but is not limited to, the following: 1) Name(s) of all people involved in the crisis situation, including participant; 2) Date and time that referral was received from CTH; 3) Dates and times that CMO was dispatched and arrived at location, with total number of minutes from dispatch to arrival; 4) Location and address where the crisis occurred and outreach was provided; 5) Nature of the crisis; 6) Name of staff who provided services; 7) Assessment of risk and the results of that assessment; including level of staffing if person is removed from setting; 8) Overall assessment of the participant and situation; 9) Services provided; 10) Outcomes; 11) Details of plan of care; 12) Details concerning OHS referral, if needed; and 13) Documentation of reason for exceeding 45-minute response requirement per the Operational Guidelines below, if applicable. QUALITY ASSURANCE REPORTING REQUIREMENTS: 1) The Provider must maintain data on: a) Performance measures • Location of the crisis; • Types of interventions used to stabilize; and • Disposition of CMO (out-of-home, emergency department, OHS, or specify other); b) Operational performance measures • Staff turnover; • Supervision occurring; • Satisfactory agency record/documentation; and • Grievances;

	2) Measurements to include, but not be limited to: a) Length of time required for Crisis Telephone Hotline (CTH) call to result in decision to dispatch CMO staff; b) Length of time between dispatch and arrival of the CMO on-site; c) Length of time from arrival to stabilization and completion of intervention; d) Percentage of CMO staff who meet qualifications and competencies; and e) Percentage of individuals who have had previous contact with Crisis Services within the last three (3) calendar months. 3) Data must be analyzed quarterly for trends and recommendations for improvement; and 4) Submit data analysis on CMO in a report to DOH-DDD on a quarterly basis.

4.20.2 - OUT-OF-HOME STABILIZATION (OHS)

SERVICE DESCRIPTION	Out-of-Home Stabilization (OHS) services [formerly called Crisis Shelter services] provide emergency out-of-home placement of adult participants in need of intensive intervention to avoid institutionalization or more restrictive placement and in order to return to the current or a new living situation once stable. This is a short-term, temporary service. Transition and discharge planning must start from admission, looking at planning for successful community living. The OHS is located at a licensed setting operated by the Provider. The Provider must comply with HAR, Title 11, Chapter 98, for Special Treatment Facilities to operate a Therapeutic Living Program where OHS services are delivered. The maximum home capacity is three (3) adults. The Provider must ensure that OHS services are: 1) provided in a safe and therapeutic environment that supports and observes the participant at all times; 2) provided in an environment conducive to recovery which provides an opportunity for individuals to stabilize to baseline or better and learn skills to promote wellness and community living; 3) delivered in a manner than ensures the capacity to adjust settings and staffing to maintain a safe and therapeutic environment at all times; 4) coordinated with referrals and all necessary services and evaluations as needed; and 5) delivered in accordance with DOH-DDD's P&P #2.01 *Positive Behavior Supports*, #2.02 *Restrictive Interventions*, #2.03 *Behavior Support Review*, and #3.07 *Adverse Event Report for People Receiving Developmental Disabilities Division Services.* The Provider must accept all DOH-DDD referrals based on bed availability.
LOCATION OF SERVICES	The Provider must operate a facility that meets all licensure requirements from Department of Health, Office of Health Care Assurance (DOH-OHCA) as a Special Treatment

	Facility (Title 11, Chapter 98, Hawai‘i Administrative Rules) to operate the Therapeutic Living Program where OHS services are delivered. OHS services must be available 24 hours a day, seven (7) days a week, including holidays.
SERVICE TIERS	Not applicable for this service.
STAFF TO PARTICIPANT RATIO	1) At minimum, two (2) direct care staff must be on duty per shift, with one (1) staff awake during overnight shifts. 2) A ratio of not less than one (1) staff to two (2) participants must be maintained at all times. 3) The provider must ensure the provision of necessary additional personnel to meet the needs of the participant receiving services for emergencies including escorting and remaining with the participant at an emergency unit, or maintaining one to one (1:1) supervision of a participant. This may include increased staff within the first 72 hours to meet stabilization needs.
TRANSPORTATION	Transportation of the participant to and from the licensed setting for OHS services is included in the cost of this service. Transportation must be provided for inter-island air travel for a participant located on a Neighbor Island to the licensed setting for OHS services located on Oahu. Non-Medical Transportation to and from non-medical services and activities is included.
REIMBURSABLE ACTIVITIES	Reimbursable activities include: 1) Receive information and assessment from CMO to prepare for participant intake; 2) Provide the participant and circle of supports with information for questions and concerns they may have when entering the licensed setting to receive OHS services that include but are not limited to: a) Description of service; b) Rules of OHS services and the licensed setting; c) What to bring/what not to bring; and d) Visiting hours/contact information;

	3) Build rapport and working relationship with the participant and circle of supports; 4) Assess need for language interpreter, and medical or psychiatric consultation; 5) Upon admission, the provider must develop an interim plan to address the participant's need(s) for crisis stabilization and intervention; 6) Conduct an overall assessment of the participant, working collaboratively with the participant and circle of supports to gather information to learn about the participant and gain insight that may be helpful in discharge planning; 7) Assess and coordinate if a higher level of care is needed for medical or psychological reasons, or if police are needed for criminal behavior. The provider must seek emergency hospitalization for a participant when deemed necessary and appropriate by provider's clinical staff to ensure the participant's safety and the safety of others. 8) A licensed medical professional must be on staff or on contract to establish the system of operation for administering or supervising medication and medical needs or requirements, monitoring the participant's response to medications, and training staff to administer medication and proper protocols. a) A licensed medical professional must be available 24 hours a day, seven (7) days a week. The licensed medical professional does not need to be on-site for that time period but must be on-call and accessible 24 hours a day, seven (7) days a week, including holidays. 9) Based on assessment, connect participant with appropriate medical, psychiatric, waiver or other services as needed: a) Psychiatric assessment, treatment, and/or consultation including psychotropic medication management and monitoring; b) Psychological assessment, treatment, and/or consultation; c) Training and Consultation (T&C) for completion of a Functional Behavior Analysis (FBA) and

	development of a Positive Behavior Support Plan (BSP); d) Medical assessment, treatment, and/or consultation and medication administration, as necessary; and 10) Coordinate with emergency medical services, as appropriate. The Provider must coordinate and notify the CM for the participant of any adverse events. The Provider must also coordinate with the family and circle of supports to be an active partner in treatment and transition. 11) Deliver crisis stabilization and intervention services within a safe environment to calm and manage the participant; 12) Provide medication management and administration. This must include prescriptive authority for medical staff while the participant is receiving OHS services at the licensed setting; 13) Provide support and family therapy, as appropriate, to circle of supports; 14) Provide a personalized discharge-transition plan moving forward that includes the participant and circle of supports in the process. This may include a safety plan, appropriate information, referral and contact number for future consultation and follow up; 15) Prepare and specify assignments, roles and responsibilities to implement the discharge-transition plan to support the participant in the residential environment he/she will be in upon discharge, so that crisis support will "fade" no later than 90 calendar days after implementation of the agreed upon plans; 16) Provide training with circle of supports as a part of the transition process; and 17) Provide follow-up services after discharge that may include support, further training, and consultation to DOH-DDD participant and circle of supports for 30 calendar days.
ACTIVITIES NOT ALLOWED	This service may not be billed on the date of admission to a hospital or for any days of hospitalization. Services may be billed on the date of discharge from the hospital when the participant returns and receives OHS services.

	Medical Transportation to and from medical appointments are provided through the participant's Medicaid Health Plan and are excluded from this service.
LIMITS	This is a short-term stabilization intervention that will not exceed 30 calendar days unless one additional 30-calendar day extension is authorized by DOH-DDD. If extenuating circumstances require that the participant remain in the licensed OHS setting beyond 60 days, DOH-DDD must authorize the extension.
AUTHORIZATION	OHS referrals come from Crisis Mobile Outreach (CMO) after they have determined the participant to be appropriate for services. Referrals may also come directly from the CM. OHS services for calendar days one through three (1-3) must be authorized by the CMO supervisor in consultation with the OHS supervisor (if different from the CMO supervisor) and medical staff. If the participant will require OHS services beyond three (3) calendar days, the Provider must seek verbal prior authorization by speaking with a DOH-DDD Branch Chief or DOH-DDD Administrator by phone. Leaving a voice message or sending an email does not constitute a request for prior authorization. Written authorization will be sent by fax to the Provider within one (1) business day of the verbal authorization. The initial period of authorization covers (4) four through 30 calendar days. A maximum of an additional 30 calendar days may be prior authorized by DOH-DDD upon the Provider's written request for the extension to the DOH-DDD CM Branch Chief or DOH-DDD Administrator. If extenuating circumstances require that the participant remain in the licensed OHS setting beyond 60 days, the DOH-DDD Administrator or DOH-DDD CM Branch Chief must review the written request for extension and authorize on an individual basis.
INTERFACE WITH TRAINING AND CONSULTATION (T&C)	When required, the Provider must secure Training and Consultation (T&C) Behavior services for completion of a Functional Behavior Analysis (FBA) and development of a Positive Behavior Support Plan (BSP) plan by a qualified

	professional or designee in accordance with Hawai‘i state law. The Provider must seek prior authorization from DOH-DDD for T&C Behavior Analysis services and ensure that OHS staff are trained and monitored by the T&C Behavior provider.
PROVIDER QUALIFICATION STANDARDS (These are in addition to General Standards Section 3.4)	OHS staff providing services to participants and their circles of support must have the following qualifications: 1) a bachelor’s degree, at minimum, in social services, psychology, human development, family sciences, or other related degree, and 2) at least one-and-a-half (1.5) years of experience working with people with I/DD and/or behavioral crisis. OHS staff must also have the following specialized training and competencies: 1) Prior to providing services, all staff must receive at least 24 hours of orientation training which covers the following topics: crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources. 2) The Provider must provide documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention treatment protocols as guided by the provider’s training curriculum, and I/DD-specific situations. Training must promote evidence-based services and best practice procedures for urgent and emergent care situations. 3) Training for staff must include but not be limited to the following topics: a) Person Centered Planning; b) Familiarity with DOH-DDD and mental health service array and other community resources and services to provide guidance and referrals to callers; c) Risk Assessment including suicide, homicide, and any other risk of harm to self or others;

	d) Screening, assessment, and intervention/treatment planning; e) Positive behavioral support; f) Functional behavioral assessment and behavioral support plan functions and processes; g) Behavioral crisis intervention system (Safety Care, Crisis Prevention Institute (CPI), the Mandt system); h) Dual diagnosis (I/DD and mental health); i) A familiarity with psychotropic medications, classifications and side effects; j) Trauma informed care; k) De-escalation techniques; and l) Cultural and diversity awareness and sensitivity. 4) All staff must show competency in the following areas: a) Following the guidelines of the Standards and their own organization; b) Showing empathy, concern and caring for all participants receiving services; c) Being able to direct and facilitate an effective interaction and avoid power struggles; d) Working with supervisors and other team members to make decisions and provide services; e) Offering choices versus directives; f) Interacting with individuals with intellectual and developmental disabilities and communication deficits; g) Ability to interact with people who are escalated, emotional, anxious, and angry; h) Knowledge of how and when to utilize problem solving, alternative choices, and prescribing steps moving forward; and i) Knowledge of how to recognize and act upon a life or death situation.
GENERAL SERVICE SUPERVISOR QUALIFICTIONS	Service Supervisors must have all of the following qualifications: 1) A master's degree, at minimum, in psychology, social work, or related field;

(These are in addition to General Standards, Section 3.4)	2) Possess a valid license to practice in the State of Hawai‘i as a licensed clinical social worker (“LCSW”), licensed mental health counselor (“LMHC”), licensed marriage and family therapist (“LMFT”), licensed psychologist (“LP”), or registered nurse (“RN”); 3) At least three (3) years of experience working with people in crisis and/or people with I/DD with acute behaviors; 4) The service supervisor must be certified to train staff in the provider’s crisis intervention system; and 5) The service supervisor must be able demonstrate to proficiency the ability to train staff on the BSP, if applicable and following training from the licensed professional or qualified designee in accordance with Hawai‘i state law. A supervisor must be on call 24 hours a day, seven (7) days a week, in the event of clinically complex or psychiatric-related situations in need of consultation, and a supervisor must be available for on-call service, consultation, direction, and case debriefings. Provider staff must be under the supervision of a supervisor. A supervisor must be on the premises of the licensed setting at a minimum of eight (8) hours per business day (Monday – Friday). If the supervisor will be away from the premises for brief periods due to meetings or weekend supervision, the supervisor must be available by phone at all times. Staff must meet with supervisor individually no less than once a month, and must be a part of clinical team meetings held monthly. Debriefings following use of restrictive interventions must occur with the supervisor and staff involved within 24 hours of the event.
DOCUMENTATION STANDARDS (in addition to General Standards in Section 3.5)	1) The provider must develop an Individual Plan (IP) in coordination with and approval from the CM or designee within seven (7) days of admission. The IP must be

	based on the Individualized Service Plan (ISP) from the CM and a service delivery approach that includes: a) Person-centered aspects of the ISP and the participant's input, as appropriate; b) Discharge criteria that include an estimated length of stay; c) Training for families, caregivers, and providers for post-discharge community-based living and services, if indicated. 2) Each shift staff will complete required documentation including, but are not limited to, the following: a) Name of DOH-DDD participant; b) Name of the shift staff who provided services; c) Date and time of shift; d) Services provided; e) Description of activities and behaviors of DOH-DDD participant; f) BSP interventions used and efficacy of interventions; g) Insights and impressions of time spent with DOH-DDD participant; and h) Follow-up, consultation or coordination needed or facilitated. 3) A special incident report must be completed for any incidents of physical aggression, threats of harm to self or others, including self-injurious behavior, suicidal ideation or attempts, and/or property destruction that creates a health and safety issue. Special incident reports must include but not limited to: a) Name(s) of all people involved in crisis situation, including the participant; b) Name of the staff who provided services; c) Date and time that incident occurred (start time and end time); d) Description of antecedents and behaviors of the participant; e) BSP interventions used and efficacy of interventions; f) Resolution or how incident ended; g) Observations of the participant after incident; h) Insights and impressions based on observation of the participant in crisis (what worked and what did not in

	supporting the participant and how to avoid future crisis); i) Documentation of supervisor debriefing with staff within 24 hours of incident in person or by phone. Debriefing will review information and insights from the incident and identify opportunities for improvement in service delivery; and j) In addition to this special incident report an Adverse Event Report Form may be required (see Appendix 5A). 4) If staff utilizes any chemical, physical, or mechanical restraints or emergency procedures as interventions to maintain health and safety of the environment, documentation must include, but are not be limited to, the following: a) Name(s) of all people involved in crisis situation, including the participant; b) Name of staff who facilitated the restrictive procedure; c) Less restrictive interventions that were attempted prior to use of restraint or emergency procedure; d) Date and time that restrictive procedure was initiated; e) Observations of the participant during the monitoring process as restrictive procedure was being facilitated; f) Time that restrictive procedure was terminated; g) Observations of the participant after restrictive procedure was terminated; and h) An AER is required per DOH-DDD's P&P #3.07, *Adverse Event Report for People Receiving Developmental Disabilities Division Services* (see Appendix 5A). 5) The provider must report a participant's hospital admission as an adverse event and follow the procedures for Adverse Event Reporting by using the AER form (see Appendix 5B for instructions). 6) Report on a quarterly basis (July, October, January and April) the provider's progress toward workforce development for RBTs. Documentation will include: a) the staff name b) date of hire

	c) status (staff has not started coursework; staff is completing 40 hours of coursework; staff has completed coursework and is performing competency work with Licensed Behavior Analyst; staff has taken the exam – did not pass; staff has passed the exam); and d) comments to explain status if needed. DOH-DDD will provide a spreadsheet template with the categories for reporting. QUALITY ASSURANCE REPORTING REQUIREMENTS: 1) The Provider must maintain data on: a) Performance measures • Safety; • Decrease in behaviors of risk of harm; and • Discharges with successful placement; b) Restraints and restrictive procedures administered c) Operational performance measures • Staff turnover; • Supervision occurring; • Satisfactory agency record/documentation; and • Grievances; 2) The Provider must analyze data quarterly for trends and recommendations for improvement; and 3) The Provider must submit data analysis on OHS services in a report to DOH-DDD on a quarterly basis.