1915-c Waiver Standards Training – Video Transcript

Hello everybody! Thank you so much for joining us today! I want to welcome everybody to this webinar on amendment number seven. Is that correct? Yeah… that's with all the other App K's.

Oh… my goodness. Oh… with the App Ks (laughing)… threw me off. So, this is for the waiver that began in 2021. And this presentation is on the standards.

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So… welcome everybody and I just wanted to take a couple of minutes to First announce that our waiver has been approved as of today our waiver Amendment. We got the email that we've all been waiting for which is the approval letter from CMS that the waiver application has been approved. And so, you may see some slides with "once approved" in the… in the slideshow. I don't know if we had time to even take those out, but it has been approved so… And I also wanted to take a minute to thank the team, the presenters and people who participated in making this amendment a reality.

I think it's a real landmark for us-- because it really demonstrates how we're trying to respond to the changing circumstances in our state. And we had a lot of input from… for example… on the moving the nurses the nursing services back in (and away from T&C) and into the certain services. That is going to be covered. A lot of input from providers families, case managers, our own nurses (Yay!) who through the years have been helping to guide us and make nursing an important part of the services. So… thanks… kudos to all of you as well. As for the supervision standards, we were inspired to look more broadly at who can provide supervision for certain services, and that group that came together and helped us to craft that. And thank you to CRB and the team, to Deb Susui and Stephen Palowski (who will hold our hands through everything) and to all the presenters today. So… with that… next slide. I want to…

Wendy do you want me to go over the agenda or you're going to do this?

Wendy: I can do this…

Okay thank you… bye guys.

Hi everyone! I'm Wendy Lino with the Community Resources Branch. So today there are a lot of slides, but hopefully you know… it makes things easier to understand, and gives you something to reference back to in the future. So today, we'll be going over the Waiver Amendment and Waiver Standards update. Navigating changes in the waiver Amendment Version B… in the… sorry, the waiver Standard Version B (as you say). Then we'll be going over Section one - General requirements and information. Section three - Medicaid ID Waiver Provider General requirements and Standards. Nursing assessment and delegation. Then section four-- which is service specific performance standards. Then there's minor other revisions and then we'll be going over some… a little bit about the rates. And then we'll have time for question and answers. So as Stacy had said… you know, if any of you have any questions along the way feel, free to go in the Q&A function and type in your questions so that we can get to those at the end of this webinar.

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So... this is (as Mary mentioned) the seventh Waiver Amendment for the 2021 waiver (which was submitted to CMS on August 1st, 2023). CMS did come back with some questions that we responded to on September 21st, and we did have time to update the slideshow to say that we did receive approval from CMS today on the waiver Amendment with the effective date of November 1st. So, the Waiver Standards Version B was issued under provisional, and was posted to the DDD website on October 2nd. The reason it's provisional is because we're still pending Med-Quest review and approval.

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So navigating changes in the Waiver Standards, I'm sure all of you have seen it before, but there is a summary of changes in the... in the beginning of the standards (pages 9 through 17), and everything throughout the standards that have been updated are highlighted in yellow.

And this version of... this Waiver Standards Version B is effective November 1st, 2023.

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So now I'm going to turn it over to Mari who will go over section one.

Mari: Hi everyone! I'm Mari Wakahiro from the Case Management Branch. I'll be... we'll be going over Section one - General requirements and Information (the Waiver overview), and we'll be looking at four... reviewing four changes in particular: the level of care re-evaluation, Individual support budgets, ISP development updates and revisions, and lastly service authorizations.

Next page please...next slide.

So, the first one, level of care or LOC re-evaluations. These are the annual level of care re-evaluations. So, we added the option for participants to choose to have their LOC re-evaluation in person or by telehealth. So, case managers can now administer the ICAP by telehealth. If you'll remember COVID App K allowed the CMS this flexibility to use telehealth to do assessments and this flexibility is now permanent with this amendment. And the next area are the individual support budgets... so the individualized support budget ranges have been updated to reflect the rate increase, and you can find this on page 37.

And next up is Earl Young.

Earl?

Earl: Sorry... I was muted. Sorry. So as far as the ISP is concerned, the development of these revisions, we did get clarification that we do require a signed consent for services in order for an ISP to be in effect. And I think that was a little bit confusing in the past (that we... that all the ISPs or the action plans received a consent form), but now we need to... it is required for a consent service in order for the ISP to be in effect. We also clarified that there is a need for...assigned consent for services for changes in the ISP that affect Service delivery. So, if there's any changes throughout the service plan year that occur, we're going to need to get another signed consent form for that service as well. An exception for emergency situations where the signed consent

for services may be obtained after the service delivery has begun. So sometimes we have situations where we have to authorize services on an emergency basis, and that's fine. And there is an allowance for us to receive the consent for services after the service delivery has begun-- for situations to address a participants' immediate health and safety needs, hospitalizations, or imminent risk of more restrictive

placement. Services may be authorized on an emergency basis, and that emergency needs to be clearly indicated in the ISP.

Okay... next slide.

This has already... pretty much been implemented by most of the case management units. But just to clarify, that the services will be authorized through Inspire. That's been ongoing for quite some time now. Upon the receipt of the participant or Guardian signature on the action plan or ISP (and again pointing out the need to have the guardian signature on both) either the action plan and/or the ISP and authorizations through Inspire would then be sent to Conduit.

Wendy: Thanks Earl!

So, I will go over next section (which is Section 3). So, things that we'll be going over are: training requirements, general staff and licensed certified caregiver qualifications, additional qualifications for service supervisors, and Individual plan development and updates.

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So, for training requirements, we did add an additional topic--which is alcohol and drug-free workplace. So, this referred to section 3.1H. So, this is required for all new hires. And I don't know... as Mari had pointed out, if you notice on these slides in the... under the title has the section and the page number of where that section is found just to make it helpful for you... for anyone who wants to use the slides to then refer back to the standards themselves. We also added four new training requirements for all new service supervisors which is: individual plan development and updates, report writing oversight and monitoring, and maintenance of participant records. And information about all of these topics are in pages... on the pages listed next to them pages 93 and 94 of the standards... 94 - 95 and so forth. And that's just to... so that you know when this is a new requirement, so agencies will have to develop some kind of training curricula and they can use parts of the standards to help them develop that. As Mary had mentioned, you know, we did have a work group that was made up of different providers that helped us think through some of the service supervision things. And, this is something that they felt strongly that all service supervisors should have some of the basic trainings (especially in IP development and whatnot).

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So, we sent out a transmittal memo regarding this, but this is the clarification for TB clearance for IDD waiver staff and licensed and certified caregivers. So, for ID Waiver staff, they're required to obtain a TB clearance prior to starting employment for a provider, and it must be obtained... the TB clearance must be obtained after the age of 16. The two-step is no longer required unless the practitioner (who's evaluating the person) determines it is needed through the screening process for TB clearance. Licensed and certified caregivers are still required to follow the requirements in the HAR.

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So additional qualifications for service supervisors... again this is the work group that we formed of different providers to help us come up with minimum qualifications for service supervisors who do not have a bachelor's degree.

So, it was to possess a high school diploma or equivalent, minimum of two years' experience providing direct assistance to individuals with intellectual and/or developmental disabilities.

The providers must prior attest to this in writing-- that the person has been employed by the agency for a minimum of six months and the... that new hire service supervisor must be under the service... or sorry the supervision and oversight of a qualified staff who will cosign with the service supervisor for the first six months of their employment.

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Just some clarification in the individual plan development and updates. As Earl was kind of going over... action plans or ISPs have to have the consent for services or sorry we need [to] sign the action plans, or ISPs with consent for services must be signed by the participant and or guardian, and that would be equal to prior authorization for the service delivery.

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So now I'm going to turn it over to Sayuri to go over the other part of Section 3.

Sayuri: Hi... I'm Sayuri from DDD Administrative Section. In the next few slides, I will go over the changes made in the financial accountability section of the Waiver Standards Manual.

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New section 3.7 called “Financial Accountability - EVV Prepayment Reviews” was added to the Waiver Standards Manual. The information gathered through EVV is used to validate that the service was delivered including: the date, number of units, and was verified by the participants prior to submission of claims for payment. EVV participation is required for all Medicaid IDD Waiver providers in Hawaii.

For chore, personal assistance, habilitation, respite, and private duty nursing claims for EVV services that do not have supporting EVV data (including number of units equal to or greater than the units in the claim) will be denied. All providers of EVV services must have no more than 15% manually edited and/or entered visits per month.

A manually edited visit is when an EVV visit is recorded from a mobile app, land line, or fob and then it's subsequently changed by a person. Manual edits also include manually entered visits. A manually entered visit is when there's no electronic check-in or checkout, and the visit information is typed in manually.

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Section 3.7 - Fiscal

Accountability Section - which used to explain the fiscal audit requirements and process is now

moved to section 3.8. In the next few slides, I will go over the changes made to the fiscal audit process and requirements. In the past, the DDD fiscal section were the only ones that were conducting fiscal audits. However, since July 2023, some of the work related to fiscal audits have been conducted by a contractor. Therefore, we replaced DDD fiscal section with auditor.

Auditor refers to the DDD fiscal section and/or a designated agency that is delegated to perform the fiscal audit related tasks. There are no substantial changes in section 3.8. However, we made some changes to clarify the requirements for the fiscal audit.

In this slide, I will discuss the requirements for the ISP prior to providing services. Please make sure to have an approved ISP and a consent for services form (or action plan) signed by the participant parent of the

minor and or legal guardian. Exceptions may be made for emergency authorization of services that address a participant's immediate health and safety needs, hospitalization, or imminent risk of more restrictive placement. Such Services must be clearly indicated as emergency services in an approved ISP or signed action plan (effective November 1, 2023). If an ISP or signed action plan clearly states the emergency services to be provided, the updated signed action plan or ISP and signed consent for services form may be obtained after service delivery has begun, but prior to submitting claims. Claims without an updated signed action plan or ISP and a consent for services signed prior to providing services or prior to submitting claims for emergency services will be subject to recruitment.

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In this slide, I'll discuss the requirements for service records.

The current waiver... I'm sorry, the current Waiver Standards Manual refers to it as "participants attendance log". From November 1, 2023, it will be called service records. Please make sure that the service records are organized and legible. Each service record must contain the following data elements: participants full name, dates of service provided (including day, month and a year), time of service provided (both start and end times with AM or PM designations). Please make sure to exclude non-billable time where the PCI participant is present, but not receiving services. One example is when a participant is waiting for transportation. The time which a participant is in the facility but not receiving service should be excluded from the time of service provided. Type of service provided such as ADH or PAB. Staff to participant ratio-- please make sure that the staff to participant ratio is clearly indicated for applicable services.

Name and surname and signature of direct support worker who provided the service. In place of name and signature, an electronic signature, a digital signature, or a unique electronic identifier of a direct support worker with an audit trail report will be accepted. And lastly, name and signature of the service supervisor who verified the service. In place of name and signature, an electronic signature digital signature, or a unique electronic identifier of the service provider (with an audit trail report) will be accepted. Missing any of the data elements above in the service records will be subject to recruitment. Up next Dr Lee, DDD medical director...

Ryan: Hello everybody I'll be talking about the nursing assessment and delegation changes

that were made. And I... before I get going, I just wanted to thank the nurses and the others that participated in our work group over the last few months. They volunteered their time and

we had some great discussions, and you know, we were able to arrive on some agreement on these changes that I'm going to present. What you see is a summary in these four bullet points here... of just some of the highlights of those changes. And, I'll go into detail in the several slides that follow. But first of all, we wanted to identify participants with nursing tasks during waiver service hours, and those tasks... assured that they would get accomplished either by nurse or through delegation of those tasks to a support staff.

As the... as it is appropriate for the participant, we have decided to build nursing back into many of the services that you'll see, and then keep RN- T&C or training consultation for just a few of those services. And then we modified slightly some of the documentation and process requirements that you'll have...

Slide please...

So... as I mentioned, you know, as agreed upon that we build nursing back into the services, and what you see is those services listed there (it'll be built back into). So it's ADH CLSG CLSI, PAB, ResHab, and Respite. And what that means is that... for the participants that have nursing tasks, they need to be identified and those staff working with them (if it's a nursing task that can be delegated and the nurse themselves feel it should be delegated)-- then that documentation and process needs to proceed.

If the nurse feels it cannot be delegated, and it needs to be done by the nurse themselves, then documentation should follow that... and then... and that it'll occur in that way. We just wanted reassurance that those nursing tasks would be accomplished, and that safety would be accomplished. Also, next slide please...

We also decided that for certain... for certain services we would maintain training consultation by an RN and those are the services listed there. That's for CD, PABs, CLSI, and Respite. Community Navigator Discovery career planning and IES (or Individual Employment Supports).

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For the assessment and delegation part of It, we're... nothing much changes. We had recommended that the provider delegation packet be used, and along with the nursing assessment plans be used, and we're going to continue that requirement. The requirements remain the same, so I'm not going to go over them in detail here. You can review it. And the nursing assessment must be completed annually (prior to the scheduled ISP). And, for participants who are new to DDD or have new services added on the nursing assessment-- should be completed within 30 calendar days of the ISP meeting (if there are nursing delegated tasks identified).

Next slide...In addition to the assessment, there is a delegation plan that needs to be created, and it must be created by an RN, and not an LPN. And the requirements, or as I mentioned, you know, must be created within at least 30 days of the nursing assessment.

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These delegation plans remain the same as far as requirements go, and so I'm not going to read off the list there, but you can...

you can refer to those pages in the section.

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This section also formatively remains the same (with no substantial changes). This is the medication or administration or assistance section, and the only thing of note is that copies of the nurse delegation plan must be in the participants record at the service site (in case we need to check on those things).

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Again, training and skills verification remains the same, and the documentation of those things remain the same too (no changes in that area).

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Oversight and monitoring. So, the nurse must conduct (at the very minimum) quarterly visits with a participant (and also whoever they delegate to). And this should also be highlighted in their nursing assessment. They can conduct the visits by telehealth (if there are no health and safety concerns, and it's

agreed upon by the circle of support and participants). However, there cannot be two consecutive quarters where telehealth is used for quarterly visits. We just want to make sure that there are in-person visits, and that you are touching base with them in person for the quarterly in-person visit by the nurse. You can use telehealth if it is extenuating circumstances that don't allow for in-person visits. Just document that, and request that. And resume the quarterly in-person visits as soon as those extenuating circumstances no longer exist.

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Oh wait... I want to go back. I want to get that last bullet point. So... documentation.

We agreed you... that the documentation can be included in the quarterlies with the supervisor, or it can be written as a separate nursing report. We'll leave it up to the provider agency nurse (depending on what they feel is appropriate).

But as we review it, we're able to view them in both. Some nurses had suggested that they have to keep it separate because it's... it just needs to be separate and seen separately, and it cannot be included, and others had said they would like to include it. And we left you the option of that...

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These again are more of the quarterly visits and review of data. And I think it remains the same (basically as we had before - quarterly).

More frequent visits must be documented (as we said), and those are the same requirements of date, start time, end time, and who's present during the nurse delegated tasks. And I mentioned also that it can be either in the provider's quarterly reports or as a separate nursing report (up to you guys how you want to do it). And I'm available to answer questions at the end.

I'll pass it on to Wendy...

Wendy: Thank you! So next.... some of the things we're going to be going over next are: the interface with T&C for certain Services, as well as the T&C reference to act 167 in session laws of Hawaii 2023.

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So (as Dr Lee was saying), you know, T&C by RN is no longer available for nurse delegation activities for certain services. So... we did remove the interface with T&C in the service specific section. And that was for ARS, ADH, CLS group, CLS individual (provider delivered only, because) it's still available for a Consumer Directed CLS), PAB (provider delivered only), and ResHab and Respite (provider delivered only). How the...

So... as I mentioned, we did add the interface to T&C for Consumer Directed Services, CLS, PAB and Respite. We also added it for Community Navigator Discovery and Career Planning, and Individual Employment Supports.

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So... we updated the reference to Act 167 Session Laws of Hawaii 2023 to clarify that.

So, in this act it clarifies that psychologists are able to supervise Respite to implement a Behavior Support plan (if that plan was developed by a psychologist). And then we also added... or sorry, we updated the

following sections of ARS, ADH, CLSG, CLS individual, PAB, ResHab, Respite and T&C. And this is all throughout section four.

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So... more along just service specific changes, there are some changes in ARS, assisted technology, environmental accessibility adaptations, SMES, vehicle mods, discovering career planning, non-medical Transportation. PAB, ResHab, waiver emergency services, and then specifically for out-of-state CLS individual and PAB.

And then, also in the hospital PAB.

So, next slide...

So just some minor changes for ARS. We clarified the intent of the service is that the ARS Worker works alongside the ResHab caregiver and not in place of the ResHab caregiver. So you shouldn't have just the ARS worker working by themselves in... while the care, the ResHab caregiver is not home or doing something else. That support is really there to help the ResHab caregiver in their hands-on work. Then, for assistive technology, environmental accessibility adaptation, specialized medical equipment and supplies, and vehicle mods, we added that the request for AT, EAA, SMES or vehicle mods must be within one year of the date of the practitioner's order (that signing of the practitioner's order).

So, in order to... for a family to request any of these, they need to obtain a practitioner's order.

And that practitioner's order is only valid for one year from the date that they sign. So they need to make that... the family needs to make the request to the case manager for the service within the one year. However, the purchase of the AT, EAA, SMES, or vehicle mod may be completed after the

practitioner's order is no longer valid (as long as the participant's needs for the service have not changed). So because of the way these services are it takes some time to get through the process of making that purchase or procuring the service. So, we do understand that it may be after that one year of the practitioner's signature, and we don't want to force the family or the participant to keep going back to the practitioner to get another order.

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Discovery and career planning.

We added that telehealth is an option for service delivery. Non-medical transportation. We clarified that a Public Utilities Commission license is only required for public transportation (such as a handy van or the bus).

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For ResHab, we clarified that ResHab may not be provided to a participant while the participant is hospitalized or when traveling out of state. We also wanted to clarify that once the provider has been billed for the 344 years units in the ISP plan year, the provider has been paid in full for the 365 day ISP plan year, and the provider must continue to provide services for the remainder of the ISP plan year.

I think a lot of people kind of know this already, but we wanted to reinforce it by actually putting it in the standards. And the authorized rate for ResHab... as sure...

I'm sure a lot of you guys already know is based on whether the home is certified or licensed versus... previously it was based off of number of beds.

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So... for Waiver Emergency Services (Crisis Mobile Outreach), we revised the requirement, the required amount of face-to-face time for... to a portion of the time of the visit (based on participants needs). It was previously... had to be 50% face-to-face, but we realize that participants have different needs. Some don't need that much, some need more. So we wanted to give the flexibility (based on participant needs). And then for both Crisis Mobile Outreach and Out-of-home Stabilization, we revise the minimum qualifications for staff up to a high school diploma or equivalent and one-year experience working with people with IDD and/or people experiencing behavioral crisis. We also added a training topic for staff for waiver emergency services to include the HCBS final rule for Community integration.

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Out-of-state travel for CLS individual and PAB. So, both services may be delivered out-of-state, but may not be delivered out of the country. The waiver only covers what's in the country. CLS individual and PAB may be provided by the primary licensed or certified caregiver (if provided in place of ResHab), and the ResHab authorization is reduced by the number of days out-of-state.

So... this [would] be when the participant is traveling with the ResHab caregiver.

PAB may be provided out of state for participants who live in licensed or certified homes receiving ResHab. So... this is when the participant travels out of state without the ResHab caregiver, they are able to receive PAB. And we also removed the limit that only one staff could provide the services out-of-state (because we're not paying for the travel). We want participants to be able... if they want to travel with two or three DSWs, and they're going to take turns providing the work, we want to give that flexibility.

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In the hospital, PAB may be provided for participants who live in licensed or certified homes. So.... they may receive PAB while in an acute-care hospital setting. So, they could not get ResHab, but they can receive PAB. And PAB in the hospital may not be provided by the ResHab caregiver.

So, the assumption is that the ResHab caregiver is still... has to attend to the other people living in the home. So... if a participant from their home is hospitalized, they would need to get the... needs assistance in... while in the hospital.

They would need to get that service from someone aside from the ResHab caregiver.

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So other minor revisions. Hoku's Online Kahu Utility is a provider enrollment system that Med-QUEST uses. And it's required that providers enroll that way versus the paper enrollment that they used to do. And their Med-Quest did get a... allowed to remove the $500 provider enrollment fee (which is great news for providers). The use of telehealth for oversight and monitoring of... for provider service delivery.

So… provider oversight and monitoring must be agreed upon by the participant and circle of supports and documented in the ISP. So this is not based off of provider convenience but whether or not the circle of supports and the participant agree to this type of service supervision, oversight, and monitoring. There was a section added to… on how the reconciliation for Waiver Emergency Services is done (because that process has changed), and Respite services do not include the cost of meals. Next slide…

So now I'm going to hand it over to Stephen Palowski who will go over rates.

Stephen: Great thank you Wendy! And good afternoon, everyone! I'm Steven Palowski with the Burns and Associates division of Health Management Associates. We are the consulting firm that's been working with DDD (I want to say since about 2015 or so) on a variety of topics including provider reimbursement. In our remarks today, we just wanted to provide some overview of the rate study that was conducted a few years back (and how it's been implemented), and some of the adjustments we've made to the rate since that study was originally completed.

So, as we move to the next slide…

Just because it's been a few years, we wanted to offer a quick trip down memory lane. And DDD, with our assistance, conducted a comprehensive review of provider reimbursement rates back in 2020. It followed the same approach that we employed in 2015-2016-- where we took a look at service requirements to ensure that payments were consistent with the state's expectations of services. We administered a provider survey to collect information directly from service providers about… how it is they deliver services. For example, staffing levels or staffing ratios, the productivity of their staff, and the like, as well (of course) as related to their actual expenses. We supplemented that data with information from other independent data sources-- things like the Bureau of Labor Statistics-- to set wage assumptions, and the medical expenditure panel survey to use Hawaii-specific health insurance cost data to set those specific cost assumptions (and the like).

Pulling those materials together (the primary data collection through the provider survey and the secondary data collection through those other published sources), we develop draft rate models which are available online. And it outlines exactly how it is we derived the overall rate. So rather than saying “we think a service ought to be reimbursed at $40 per hour”, it's based upon assumptions related to this wage level, and this benefits package, and this level of agency administrative expenses, and the like. After we developed the draft rate models, we had a public comment process where we solicited feedback on our recommendations and made a handful of adjustments in response to the feedback that we received.

For those folks who are interested in the lengthier explanation, you can see (I think) a different presentation as well as the actual rate models themselves at the link provided here. I spent a minute or two just walking through the process for the previous rate study--because, although we're just now finalizing implementation of those rates, it is more or less time to effectively revisit that rate study. CMS, the federal government, expects states to conduct a review (at least of the methodology for using rates every five years or so).

We're just about back in that time frame and then to align it with the state's budgeting process. We're actually going to be doing most of the rate study work in say… the first half into the middle of 2024.

So that can inform any sort of budgetary request for the legislative session in January of 25 (with then any potential changes in rates being implemented funding-dependent in July of 2025). So, for the providers

listening to this phone call, Stay tuned for more information. Sometime early in the new year, we'll be putting out a provider survey to again... go through this data collection process.

We're going to do some preliminary meetings here over the next couple of months to set that groundwork, but the bulk of providers will start to be engaged here again in early 2024.

Returning though to the work that's already been done on the ...

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We've made some adjustments to what was originally published. Most importantly, we've updated the rate models to account for the states' increase in the minimum wage. I want to make a point before I talk about some of the details of those adjustments.

The first is that we do not, as a consultants, nor as the division, consider direct support to

be a minimum wage occupation. However, it's important to recognize that it is relatively speaking lower paid, and so as the minimum wage goes up obviously other jobs become somewhat more attractive. And, in order to ensure that there's still some degree of competitiveness amongst service providers, we need to increase the rate model so that providers ideally can afford to pay their staff more and maintain some premium above the minimum wage (so that we are continuing to stay ahead of those minimum wage increases). In a different time, I can provide a much lengthier explanation about how it is we make the assumptions about how an increase in the minimum wage will impact people that are already above the minimum wage. The Congressional budget office, as an aside, does something similar.

So when they talk about increasing the federal minimum wage, their research shows that the majority of the impact is not by people who work at the minimum wage (because there's not a lot of people who truly earn the minimum wage Federally), but it impacts folks who earn a little bit more.

And we refer to that as the spillover effect, right? So, if you're earning a little bit more than the minimum wage, you're probably going to need to get a pay raise again to keep that position competitive and to make the employee happy in their position. So, there's quite a bit more science behind our approach to calculating those spillover and compression effects.

We've done (I think) other presentations to the Hawaii provider community about how do we approach that. So, I won't. And I don't have time to go into those details here today. But nonetheless, we wanted to highlight that we have made adjustments to the rate models-- both to account for the increase in the minimum wage from $10 to $12 (which was effective back in October of 2012) and then to the pending increase in the minimum wage to $14 an hour (which will be effective in January 1 of 2024).

In addition to updating the wage assumptions (which of course increases the rates), we also wanted to build in some of the expenses related to personal protective equipment. And that was done for a couple of reasons. First, the way it's being handled (out of necessity, obviously during the pandemic) has become somewhat administratively burdensome, and we wanted to relieve that burden on providers as well as on DDD. And then, it's also important (I think) to recognize that right now that is the new normal. So, this is expected to be a more ongoing expense as opposed to a one-time need. And for those two reasons, what DDD decided to do was to build those expenses into the underlying rate models. So, for those of you who like to look at the details and were to pull up the most recent iteration of the rate models, you'll see that

there is line items for personal protective equipment. The amounts end up being relatively modest in the scheme of things-- because it's a cost that gets spread over an entire year's worth of service. But nonetheless, that is how it is. We want to account for that expense similarly or in parallel because PPE is now part of the underlying rates for services like PAB and ResHab and ADH and the like.

Their SM... SMES or specialized Medical Equipment and supply service can no longer be used for PPE. So that's what the mechanism was during the pandemic (under the Appendix K Authority). Now that we've built into the rates, the service SMES can no longer be used for that personal protective equipment. And then I want to wrap up on my final

slide just by talking about the implementation behind these rates. So given the nature of the world, when we wrapped up at the rate study which was in 2020, obviously the state, and the country, and the world were in the throes of the pandemic.

Hawaii was hard hit by the decline in revenues (before some of the federal dollars started flowing) and so when we recommended increases that average about 20% in provider reimbursements, the state was not in a position to move forward with those increases, right? The state's revenue, the state's budget, simply did not allow that. Later the federal government did provide substantial additional funding to all the states through the American Rescue plan act, and DDD used the dollars that it received through to... amongst other things... increase provider reimbursement. And we did that through a multi-step or multiphase process. First, we did an increase of 50% of what had been recommended (effective July 1 of 2021). So, if we had recommended increasing a rate by $3, one half of that amount was $1.50-- so that $1.50 was added to the previous rate.

And again, that was just a recognition that we didn't at the time believe that we had all the funding necessary to fully implement the rates. What we could afford to do, based upon our estimates, was one half of the rate increase. Because of available funding, as well as some depression in service utilization as a result of the pandemic, we were ultimately able to stretch those federal dollars further than first anticipated. And effective October 1st, 2022, DDD was able to fully implement the rate study recommendations (with the increase associated with the $12-an-hour minimum wage). And then finally, DDD requested and the... ultimately governor and legislature supported funding into DDD's budget to allow those new higher rates to be made permanent (it's now part of the base budget). And that's an important (although subtle shift).

Providers don't really see it-- because the rates are staying the same. But if we hadn't received that investment in that legislative and executive support, ultimately, we would have had to roll the rates back to where they were in June of 2021. So, really appreciate the leadership across the state of making the investment to make those rate increases permanent. And furthermore, they also accepted the division's request to provide additional funding to further increase the rates to account for the $14-an-hour minimum wage.

Just because of the financial position the Department's in, they're actually able to move that increase forward a bit, and implement that... those changes November 1st of 2023. So, it accounts for the January 24 increase in minimum wage, but we're doing it two months early again to put more money into the provider community.

So, that's the lay of the land at this point. There's no further rate increases scheduled, right? This gets us to the minimum wage adjustment. The next one doesn't occur until January of 2026. And so, we'll be conducting the rate study here in 2024-- which will inform hopefully budget discussions that would be

effective ultimately in the summer of 2025. So, we'd gotten a number of questions from providers about what the rates are going to be. I believe those are now posted online-- so you can... you can pull down those rate models. And as it currently stands, of course, we've been living in a world that's a constant change for the last few years, but right now there's no further rate increases contemplated between now and 2025 (at the earliest).

There's no more money in the division's budget for further adjustments. So with that, I'm going to turn this back over... And I apologize, I don't know who's picking back up.

Mari: I think I got you next for closing out okay... Everybody that was a lot of information. We still have all of our panelists available. We're going to go into answering questions that have been posted in the Q&A panel list. Do you have any final thoughts before we do that? I'm going to give you a few seconds to think if you want to ask anything of our attendees while I post the slides one more time. Just a second.... So, in the chat you should see... it's a repeat. So, if you have them already, it's the same exact slide deck. I just posted it into the chat. The next thing you're going to see in there is the link to the document. And this is the document for the Waiver Standards Manual B. Okay. And the last link I'm going to share is the link for the rate study.

Mary: So, are you going to go through the Q&A?

Stacy: Just a second... let me post this link. Okay here we go... all right. So, I think everybody is caught up with things shared in the chat. For Q&A, we... you're welcome to continue to post Q&A questions. I'm going to move my screen over here a second. Okay. Maybe... that's lot of questions.

Huh... okay. Let me see if I can organize a little better. All right. Question -- so panelists I'll need your help if you could turn your camera on (if this is a question that you're able to answer). First question is “what are the telehealth parameters for case managers? On page 124, it explains telehealth for providers only."

[No Audio]

Mari: So, in the standard, you're right it...page 124 does not address case management parameter / parameters for case managers. It does address it on page 36 and page 39 of the standards, but it's brief. And so, this is something that we'll be taking back to our supervisors, and discussing with them and letting you know later.

And so, this is for the first and second question about telehealth.

Stacy: Okay great... thanks Mari! The second question was about ICAPs: "if the ICAPs are done via telehealth, and the participant is participating, can it count towards a quarterly face-to-face visit?"

So, Mari just summarized and said those are two of the questions that will be taken back for more operationalized discussion. Okay. So, the next question we have is about identifying consent for services— “How do you identify the consent for services form for changes made... to every change made to the ISP? If there are changes made to the action plan, there is no comment section in Inspire to type in what changes are made to the action plan."

Mary: This also sounds like an operational case management question-- so I'm going to point back to the same thing that Mari said... that... that will be conveyed to the case managers directly.

Stacy: Okay. All right... thanks Mary! Okay! Moving on... "do DSPs still need an annual TB clearance?"

Wendy: So, DSPs need to have a TB clearance, but as long as it's obtained after the age of 16, the provider just needs to keep that on file, and the DSP does not need to go and get a new one every year. They would, if they get selected in the validation... staff validation process, the provider would just submit the one that they have on file.

Stacy: Okay great... thanks Wendy!

Okay next question, "when provider agencies are audited, what are [they] required to send?

So, both or just either one of the ISPs and/or the action plans (if signatures are only required on either or documents).

Sayuri: So, the ISP with consent for services or ISP approved ISP with the action plan is

required. Does that answer the question?

Stacy: Patrick if that doesn't answer your question, can you try one more time to answer... to ask your question in the in the Q&A and we'll get back to you, okay? Next question- "Who is responsible for informing and enforcing CD employers to use the EVV?"

Wendy: So... for EVV, Acumen is assisting our division with making sure CD employers are informed and trying to work with them to provide technical assistance (if they're having problems with EVV). But I guess, ultimately, the division, or the state, is responsible for enforcing the use of EVV for CD employers.

Stacy: Okay... all right. Thanks Wendy! "Can an agency bill for ADH service during transportation when using their own van (claiming staff are managing behaviors during the commute)? "

Wendy: So, I want to try to address this but Stephen or Deb if you have anything to add... Transportation is built into the rate for the ADH service-- so should this... ADH service should not be billed during the transportation time. But Stephen, you came on camera. Chime in.

Stephen: The demarcation point is if it's in program transportation or not. So, the cost of transporting people to and from their homes between their home and the program is not intended to be billable. That's Incorporated in the rates across a couple of services (depending upon an individual situation.) For individuals who are in the community's part of their program, that billing ought to flip over to CLSG and that in program, transportation would be billable right?

So if you're taking people from the center to an activity in the community, that transportation time would be billable (is my understanding), and you, Wendy, obviously can correct me, but that's... that I believe is the distinction that we make in terms of what type of transportation we're talking about.

Wendy: Yes... so going out into the community is billable, but it's billable under CLSG. Stephen: Yes.

Stacy: Okay. Great... thanks Wendy and Stephen! All right. For T&C RN-- "is T&C RN... will it be required for RN delegation task using CD Services? If so, which agencies are accepting to do this?" Not known. No known providers have been willing to do T&C RN for CD workers. How is the branch going to resolve this problem?"

Ryan: I can start off on this one... it's Ryan. So yes. T&C- RN is required for those participants with nursing tasks (if they are receiving CD Services). The reason why we did this is because there were a number of

participants with nursing tasks (some of them very complex) that did not receive any type of oversight whether or not these tasks were being accomplished, accomplished safely, or well. And, so we did make it a requirement as far as what agencies are accepting to do this. I am not sure… there may be some agencies on this call now that that can identify themselves if they are accepting to do this, but we made this a requirement because of the safety concerns and the lack of monitoring and oversight that had been occurring for CD services for those with nursing tasks that needed to have them either performed by a nurse or delegated to somebody, and then overseen.

Stacy: Great… thank you! Thank you, Dr Lee! Okay for providers - "can provides… can a provider submit their own nursing assessment to begin providing RN Services?" Same for annual submissions.

Ryan: The answer is no. I know we discussed this previously, but there wasn't a consensus on whether or not we could appropriately monitor and oversee every individual provider agency's nursing assessments. And so, we decided to go with the process that was already in place previously (which was to require provider nursing delegation packet along with nursing assessment provided by the DDD to be done (rather than the nursing assessments for their own provider agency). And I think you'll find that ours is quite comprehensive, and includes much of the components of each provider agency nursing assessment. So that can be copied and pasted over (if you need to), but much of it is overlapping and the same. It's just that we wanted to maintain consistency within the division.

Stacy: Okay…. thanks Dr Lee! All right. Out-of-state travel, PAB, and CLS individual-- if PAB or CLS individual is provided, the total out-of-state days will be subtracted from the ResHab total of 344 (and not 365).

Wendy: So, for out-of-state travel and CLS (from when the participant is traveling with the ResHab caregiver), then the number of days would be subtracted from the 344.

Stacy: Okay… thanks Wendy!

Okay… please provide the link. Okay… so we did provide that. Done. Is Telehealth… is agreed upon? It says: "Provider must submit written assurance for review by the Developmental Disabilities Division compliance officer. How do we send this? Is there a form, or do we just put what we are using to comply?"

Wendy: So… I believe the guidance that we had provided before was that the provider must document what… how they are complying (that it is a HIPAA-compliant platform), and what types of features are in place. And then they would, excuse me, keep that on file… and DDD may request that from them at any time.

Stacy: Okay got it… thanks Wendy! All right. "We were instructed that if there are any mid-year changes that affects the ResHab rate we subtract the days from 365, and if the balance is more than 344, then the maximum case managers authorized is 344. But if the remaining balance is less than 344, we authorize the actual amount. So, if the caregiver takes the individual with them on vacation for only 7 days and gets paid with PAB / CLS individual service then do case manager subtract the seven days from 344 or from 365 (in which the authorization would remain at 344 for the plan year)?"

Wendy: So… they would reduce the authorization… the 7 days from the 344.

Stacy: Okay… got it! Okay thanks Wendy! "For participants who need T&C, will the two hours that nurses use to bill for the assessment be included or will it be separate?"

Ryan: So… I'll take this one. You're referring to participants who need RN-T&C (which would be for the CD, PAB, CLSI, Respite, Community Navigator, DCP, and IES). And I… my understanding is yes, that when you complete your nursing assessment, then you can request two hours to complete the nursing assessment. And then additionally, you'd be requesting hours to carry out the RN T&C, and that would be evaluated as previously in the RN T&C process.

Stacy: Okay great… thanks Dr Lee! Stephen the next one is for you… The question is about explaining how the nursing services are built into the rates, and how should we allocate budget for our nurse staff given the rate allocations.

Stephen: So… to the first part of the question, I believe that the links to the new updated rate models have been shared-- that they're available online now. So, if you look at one of the services that Dr. Lee referenced-- as those supports now being built in the rate-- you're going to see a new section of the rate model. I think it's called nursing supports. And the way we integrated it was… making some assumptions about the number of individuals that well… the number of individuals that an agency could provide / is providing services to for which they'll need a single nurse.

And… I apologize for being a little bit stilted in that explanation. Because what we're getting at is not everybody of course needs T&C by an RN. But we didn't want to set up a more complicated fee schedule where you're going to have one ResHab rate where people do need nurse delegated tasks and a different ResHab rate where they don't need nurse delegated tasks.

So instead, what we've done is more of a population model where we're funding one nurse for every X number of participants. Now, that's not to say that the nurse is providing oversight for that number of participants. In fact, we assume that they are not providing oversight for that number of participants, but within a population of say 50, you're maybe providing nurse delegation for 20 individuals. So that's the basis for the rate, and you can see the specific assumptions within the individual rate models in terms of how we derived those assumptions. We started with the provider survey we conducted back in 2019.

I will acknowledge that it wasn't set up to ask for information exactly the way that we're using it now right-- because this is a change to the approach for paying for nurse delegation. So… but that's what we had available to us. We also considered ratios that we put in place in other states that have a similar sort of model. That will be one of the things that we're absolutely focusing on though for this new rate study I've been talking about. So, we did the best that we could with the data that we had available to us (and some benchmarking work to set up the current assumptions), but that will be something that we will evaluate in the rate study that I referenced beginning here in 2024. The second part of the question on how should we allocate budget for our RN staff (given the rate allocations). I'm really not in a position obviously to answer that on behalf of any specific organization. If you want to know how much funding is in the rate model for that-- you'd go back to the rate model (because it is a separate section). And it's going to say: for ResHab it's X dollar per day per individual is built in for nursing.

And, of course, then you could do the math on behalf of your own agency to say well… I'm serving 50 people in ResHab. You know they're in care an average of 340 days-- so that's giving me what… 1,700 days of service and multiply it by the amount that we've allocated for nursing.

That's how much revenue that you're generating for nursing supports. But like all rate model assumptions, they're just that… that you don't have to have that money specifically pulled out to say "this is the amount that we have to spend on nursing."

You might spend less, you might spend more, but if you wanted to know how much is funded, that would be the approach that I would take.

Stacy: Great... thank you very much Stephen! Okay, what will happen if the provider goes over the 15% EVV adjustments?

[No Audio]

Wendy: So, there's many different steps. MedQuest issued a memo back in December, and then an updated memo in February, and I believe another updated memo in September. But for providers who go over the 15% of manual edits for EVV, they'll initially get a warning letter, and then it could move to a corrective action plan. And then it could move to sanctions-- where provider claims will be withheld a certain percentage. That has not started yet... but that's the process... as of now.

Stacy: Okay... that's clear! Okay with the new rates as of November 1st, will new authorizations be generated?

[No Audio]

Mary: Wendy, can you take that?

Wendy: I don't think so... but I don't know for sure. But I don't think new auths would be generated.

Stacy: Okay. All right! For... let's see...Chalee is asking: "my agency recently completed a second fiscal audit this year by Myers and Stauffer. Will fiscal audits now be conducted twice a year, or will the company contracted by the Department of Health be the sole fiscal auditor going forward? "

Sayuri: So, the fiscal audit is conducted based on the state fiscal year. So, it's conducted annually once a year--unless you score below 86-- and you have to go through a cap and follow up audit. Then you may be audited twice a year.

Stacy: Okay, thank you Sayuri! "In regards to the RN being built back in during the work group meetings, I thought it was discussed that we can use our own provider assessments (as long as the assessment has the same information as NPA that the Department of Health provides.) Is this still the case or is it mandatory that we use the assessment provided by the Department of Health?"

Ryan: Yeah... so whoever this is... they're right. We did discuss it. In the work group meetings, we ran it by our own nurses and others, and ultimately it was decided that that because of the purposes of oversight monitoring review and also for data purposes that we would maintain what is the current status (which is to use DDD's packets with the assessment.)

So, it is mandatory that you use the ...DOH assessment packet.

Stacy: Okay... thank you for clarifying Dr Lee! Regarding the EVV, many DSWs are having issues with clocking in and out, and it's a timely process to conduct contacts and SAND data for health. Will the providers be penalized for the manual edits still?

Wendy: Short answer is... yes. But, however, providers should keep track of issues with SAND data and submitting tickets to SAND data for issues... problems with the devices or whatnot. Because if a provider is over the 15%, but you show, you know... you have all of these tickets with SAND data-- that all these issues were occurring, then it might be something that we... that we can work with MedQuest to you know-- to either not penalize or figure out some... a different process (especially if it's problems with SAND data).

Stacy: Okay. makes sense! Thanks Wendy! "Is the two-hour nursing assessment already included in the rate increase?"

Ryan: I don't know the answer to that. Maybe Stephen knows, but I did comment on the 2-hour RN assessment for those services for which RN-T&C is still applicable. So, for the other services, I'm not sure. Maybe Stephen can come.

Stephen: As it relates to those services where the nurse delegation is now bundled into the rate.. that's kind of the all-inclusive amount and those costs are now reflected in the rate models that will be in effect on November the 1st. We don't break it out in terms of... again the specific tasks... nor even the number of hours in total that a given participant is going to get. It really is based upon that population model-- that for every X number of individuals receiving a given service, the agency needs one nurse in order to handle nurse delegation (recognizing some folks get delegated tasks or need delegated tasks and others do not).

So that was a lengthier explanation. The short answer is: the rates include everything that's going to be included for it being bundled back in. As I said in my previous response, that will be a cost that we'll be looking at closely through this next rate study.

Mary: Can you remind me how Maui might be a little bit different because of the Appendix K that applies just to Maui County participants? Did we begin those rate increases in August (at the start of the plan period).

Stephen: Right... And if I don't hit the points you want me to hit?

Mary... feel free to let me know...But the... in response to the wildfire declared emergency, the state's again relying on appendix K authority (just like it did during the pandemic) to move forward with a number of flexibilities as well as to do some temporary rate increases, and a very limited retainer for providers delivering services on Maui. In the case of the rate side of things, the services are being reimbursed at 125% of what the fee schedule would otherwise allow for. So, if a rate was $10 per quarter hour, during this appendix K period, it's going to be reimbursed at $12.50. That's not targeted specifically to nursing, right? We're not making adjustments for individual components of the rate.

We're just saying that we're adding a 25% TRA, or temporary rate adjustment, for all services delivered in Maui County.

Mary: Thank you!

Stacy: Okay! Thank you! Okay... "is it imperative to have an RN as service supervisor for Respite?"

Ryan: So, my thought on this question is I believe it is not. I'm not telling you how to run your business and how you want to do it, but if you have an RN as a supervisor for ResHab (or any of the other services for which it's bundled in) that's up to you. We are not making it mandatory that you have an RN as a supervisor. We just want an RN to do the nursing assessment and assess for task, and then.... and then delegate as appropriate.

Stacy: Okay. Thank you, Dr Lee! "Pertaining to participants that live in licensed homes-- when participants go to the hospital, ResHab needs to find someone else to provide PAB at this time. Am I understanding this correctly? If so, is any provider... is another provider agency able to help support that participant with PAB during that emergency time?"

Wendy: Yes, and it's not really... not necessarily up to the ResHab caregiver to find a PAB worker. It... I mean, that would really be through the circle of supports, the case manager. Because the case manager would have to authorize the PAB, and definitely another provider agency could be the one to provide the PAB while the person is hospitalized.

If that person needs the additional supports while hospitalized... okay.

Mary: And just to add to that... just because... sorry the way the question is asked not everybody who goes into the hospital may need a support worker (DSP) with them. So, this is only for the people where it's indicated, or it's needed. Yes... okay! Also, just to clarify... the T&C RN will be removed... will be removed to CLS individual group, ResHab, ARS, PAB services.

Ryan: So just to clarify what we mean, this... the service of T&C is not... is no longer something that we're going to authorize within those listed services. However, if somebody is receiving waiver service hours during those services, and they have nursing tasks, they should receive... they should get a nursing assessment done and receive either delegation or services

through an RN (because they have the nursing task, and those have been bundled in).

So... yes! The authorization and the service itself for authorization hours has been removed from those.

Stacy: Okay... thank you Dr Lee! "Once a caregiver is paid the maximum 344 units... 344 units... this covers the entire year of 365 days. When a caregiver goes on vacation and respite caregiver is with another provider, is a case manager to add additional units up to 365 days, or are they to transfer the units over (because every agency has a different way of calculating how they pay out their caregivers for the 344 days)?

[No audio]

Mary: Ethan or Wendy (laughs) ... this is your question.

Wendie: I would think... case management would respond. But Stephen, if you have...

Stephen: The first part of the answer... is that no there should not be an additional 21 days authorized. The 344 is meant to be a 300 is meant to be... 300 is meant to be equivalent to 365 days-worth of revenue. So, if a caregiver chooses to go on vacation without the individual, and then that individual needs to be supported by somebody else, that ought to be worked out in the agreement between the ResHab agency and that caregiver.

So... the agency, again like Dr Lee said earlier, it's not the division's responsibility to tell folks how to run their business. But were it me, I'd hold back some of the funding to say... we're going to need those dollars to pay somebody else to provide care to the individual while you were on vacation-- because the 344 is a maximum that that individual is going to be authorized (whether that Respite is provided by the same agency or a different agency). The 344 is that limit.

Stacy: Okay. Hopefully that's helpful to the person who asked the question. If not, please reply again into the Q&A so we can answer it again. "Since the T&C-RN service rates are inclusive, how do agencies allocate in the budget report?

Ryan: So... I might need Steven's help to answer this because I'm not sure. But I can take a swing at it and thanks CJ for your question. But the way I would go about it is to look at who (as far as participants... number of participants) in your... in your participant profile have nursing task needs.

And then identify how many hours you're going to need as far as a nurse for those services (versus delegating those tasks out). And then decide on the cost of the nurse... and other costs.

And then put it into the budget... therefore... or if you have to contract out for nursing.

But Stephen, do you have a better reply on how to approach that?

Stephen: I guess I'm not sure, and perhaps you know Dr Lee? When the term budget report is being refer to, I don't know what that... what's being referenced there.

Ryan: Oh... I.... Maybe they're just wondering how to budget for it (for those services)?

Mary: Could it mean the reports that people are submitting during the public health emergency using the ARB funds, etc.?

Stephen: So... if so... it doesn't need to be reported there. We're not looking for nursing staff in that DSP Workforce report. That's just for the direct support professionals. If it's as Dr Lee interprets (which is as good interpretation as I would offer), it's what I think we responded to earlier in terms of understanding how much your organization is going to get funded.

But it's... it really is spread across everybody (not on a per person basis). So... it's... it's like a lot of other costs within an organization. We have a standard mileage amount (for example) built into the ResHab rate. But some folks might get more transportation than another individual. And the... in terms of how you allocate those mileage dollars, that's going to be an agency-by-agency call. The same thing is true with these nursing services we're providing. What we think is an average amount spread over everybody... that you're building services for some folks are going to get delegated tasks and other oversight, and other folks are not. So... you can look at the model and knowing the population that you serve, know the total amount of funding that you're going to need or receive (I should say). And, then obviously working with that revenue pot, figure out what is the best way to allocate across individuals. But of course, the bottom line is making sure that you're compliant with the rules and regulations about providing appropriate nurse oversight when those delegated tasks are necessary.

So... I'm sorry that there's not (perhaps) a more specific answer, but it is like any other now that it's built into the rates. It's like any other assumption. It's a... it's meant to be a typical amount without necessarily being specific to a given participant.

Thanks Stephen!

[No Audio]

Wendy: Stacy, you're on mute.

Stacy: So sorry... Laura Lee is just making a comment here about cradles and crayons being identified as an agency providing T&C -RN assessment and delegation oversight services. They currently provide the services for another waiver provider. Thank you. Okay! "How do we get reimbursed for off Island medical appointments (especially when they are overnight)? Do case managers add CLS individual units to their budget?"

Wendy: I'm going to take a stab at this, but if anyone wants to jump in feel free. For medical appointments, I think that service... that should be sought through the health plans first (before waiver).

[No audio]

Stacy: Okay... makes sense! Thanks Wendy! Okay... thank you! Just curious... oh... she's... I think she's making a comment about her previous comment regarding the audits. This year was Jan-- did not result in findings or require cap. Okay... great! All right! "If a CD participant needs T&C RN, who determines that there are nursing needs? Who fills out the nurse delegation plan?

Currently, if an agency participant needs T&C RN, the agency RN determines the nursing needs and fills out the RN delegation plan."

Ryan: So, I... I can't speak for case management, but I think that we can assist with that at the ISP level (when we get to know a participant). I know that there's, you know... some debate over whether we need to have it done before that. But we should be able to assist in identifying (specifically for those with CD services) who has nursing tasks. And then, I think it would be upon the CD provider to be able to determine (filling out the RN delegation plan), and not the DDD to do that for them.

Stacy: Okay... great! Thanks Dr Lee! "For those who are already in process of the year, and have hours that are being... that are being currently utilized, will those billing hours continue through the end of the plan year, or will that be changed as of November 1st?"

Ryan: I don't know the answer to that. Maybe somebody else can help me with that part (as far as new authorization)?

Wendy: So... for T&C-RN... for services ADH, PAB, non-CD, it'll end October 31st, and it will not continue throughout the remaining... of the plan year.

Stacy: Okay good. That's important... okay. So... will not continue beyond Halloween (beyond October 31st). November 1st is new. "On page 9... 199, PAB Services may be provided in an acute care hospital setting. So, does that mean the case manager needs to meet TCM requirements and needs to lift the hospital suspension-- so PAB billing can occur?"

Wendie: I'm going to ask case management to jump in, because I'm not too familiar with the TCM requirements. However, it's my understanding that... so when a participant was hospitalized in... waiver Services would be suspended. But that is no longer the case. The waiver does not need to be suspended if someone is hospitalized. So... if the participant needs services while... or additional supports while in the hospital (above and beyond what the hospital staff is already responsible for providing) then PAB can be authorized (for while in the hospital).

Mary: I would ask Earl and Mari-- if we could add that to the case manager operational explanations? Because this Hospital suspension at... hasn't been in effect for a while. It's a part of the American Cures Act.

Stacy: Okay... thank you!

Stephen: That is correct! We have not been suspending when you're going to the hospital, and we continue to offer the services (such as PAB) while they are in the hospital (if necessary).

Mary: Okay... thank you!

Stacy: Okay... will rates change online to reflect the additional increase (beginning November 1st)?

Wendie: So... I'm not sure what online means? Whether or not they mean in the building, in the conduit system, or...but we are working to get everything in place. However, I don't know that we will have everything all set up for the new

rates-- the increase in rates (to begin to bill) on November 1st (because that's right around the corner). But we are working as fast as we can, and we will let providers know when everything is in place to bill at the increased rates.

Stacy: Okay. So... for most services, there is no more separate billing for T&C RN? Correct?

Ryan: Yes! You are correct!

Stacy: OK.

Ryan: Those Services listed that we... that we talked about.

Stacy: Okay.... Great! "Can we get a link to the new rates?" We will include... so for everything that you've seen on the screen and that's in the chat, we will include it as part of the webinar posting on the DDD website. So... we should be able to get that up before the end of next week.

Mary: In terms of the rates, Wendie, wasn't the new rate sheets sent out to each provider?

Wendie: We did not send the individual provider specific rate sheets. Just the rate study was linked to the website. So now that we got approval, we'll be working on getting all of that prepared.

Mary: Thank you!

Stacy: Okay. Rosemary is asking for clarification. "Now that NSG delegated tasks being... are being put back into ResHab services, does the nurse need to provide a quarterly visit in-person, telehealth and a quarterly summary?"

Ryan: The answer is yes. So, oversight monitoring continues for those services-- even though they're built back in. So... the nurse will have to do quarterly, in-person or telehealth visits based on the constraints we mentioned. And then, also provide either an independent RN quarterly summary, or it can be built within the quarterly summary of the service provider.

Stacy: Okay... thank you Dr Lee!

Mary: Dr Lee, can I ask you a question about... that some people may need more than quarterly visits at check-ins because...

Ryan: Yeah... you're right! I mean we state in the standards that at a minimum quarterly. So Mary's saying that, you know, if somebody is more complex or has additional needs you may want to do it more, and we'll be looking out for that too.

Stacy: Okay... thanks Dr Lee! I'm just looking at the time. It's 2:31. I know this webinar is scheduled to end a minute ago. Would the group like to continue? We have several more questions. Or would we like to stop now?

Mary: What I'd like to do is take the rest of the questions, and distribute the question and answer for each of them. So… let's make sure we… that we capture the questions that are in the chat, and we can respond in writing. I hate to hold people up from their… the rest of their afternoon.

Stacy: Okay… sounds good! Are there any closing remarks from our panelists? We good?

Okay… attendees. Thank you so much for your time! Thank you for being here to hear all of this information. If you have any other questions, feel free to send an email. Feel free to check in with us, and let us know if you have any more questions along the way. But thank you very much!