Waiver Standards Webinar – Questions and Answers (Q&A)

Attendees shared questions using the Zoom Q&A feature. Questions and answers pertaining to various sections of the Waiver Standards changes effective November 1, 2023, are listed by Waiver topic.

Electronic Visit Verification (EVV)

Q1	Who is responsible for informing and enforcing consumer-directed (CD) employers to use the EVV?
A1	Acumen is assisting DDD with making sure CD employers are informed and providing technical assistance if CD employers are experiencing problems with EVV. Ultimately, DDD is responsible for enforcing the use of EVV for CD employers.

Q2	What will happen if the provider goes over the 15% of EVV adjustments?
A2	In a December 2022 member, the Department of Human Services (DHS) Med-QUEST outlined several steps related to EVV adjustments. Updates were shared in memos distributed in February and September 2023. For providers that go over the 15% manual edits for EVV, they'll initially be issued a warning letter. From there, if manual edits continue to exceed the 15% limit, the provider may be subject to other requirements such as a corrective action plan or sanctions, where the provider's claims could be withheld for a certain percentage.

Q3	Regarding the EVV, many direct support workers (DSWs) are having issues with clocking in and out, and it's a timely process to contact Sandata for help. Will providers still be penalized for these types of manual edits?
A3	The short answer is, yes. However, providers should keep track of issues with Sandata and submit tickets to Sandata for problems related to their responsibilities. If the provider is over the 15% EVV manual edit limit, but can show documentation of issues with Sandata, DDD can follow-up with DHS Med-QUEST on how to address this.

3.4. C General Staff and Licensed/ Certified Caregiver Qualifications (page 85)

Q4	Do DSP's still need an annual tuberculosis (TB) clearance?
A4	If a TB clearance was obtained after age 16, the DSP does not need to get a new TB clearance annually. The provider needs to keep the DSP's TB clearance documentation on file. In the staff validation process, the provider would submit the documentation on file.

C. Oversight and Monitoring Responsibilities (page 96)

Q5	If telehealth is agreed upon, it says the provider must submit written assurance for review by the DDD compliance officer. How do we send this? Is there a form or do we just put what we are using to comply?
A5	Providers must document what they are doing and how they are complying with using a HIPAA compliant platform, including describing what types of features are in place. This documentation should be kept on file. DDD may request this documentation at any time.

3.8.A Documentation Requirement for all Billable Claims (109)

Q6	When provider agencies are audited, are providers required to send both or just either one of the Individualized Service Plans (ISPs) and/or the Action Plan, if signatures are only required on either/or documents?
A6	The ISP with consent for services or the approved ISP with the Action Plan is required.

Q7	My agency recently completed a second fiscal audit this year by Meyers & Stauffer. Will fiscal audits now be conducted twice per year, or will the company contracted by the DDD be the sole fiscal auditor going forward? Just curious because our first audit this year was in Jan 2023 did not result in findings or require a CAP.
A7	The fiscal audit is conducted annually based on the state fiscal year. If your audit score is below 86, you have to go through a cap and follow up audit, which means you may be audited twice in the same year. The state fiscal year runs from July to June. So, you may get audited again, for example, in November of 2023 (FY24), when you were already audited in, for example, January of 2023 (FY23). Please email DOH.DDDFiscalAudit@doh.hawaii.gov if you have additional questions.

Q8	What is the end date to submit billing for T&C RN services that have hours that were completed prior to 11/1/23?
A8	Providers have one year from the date of service to submit claims.

Waiver Services

Adult Day Health

Q9	Can an agency bill for Adult Day Health (ADH) service during transportation when using their own van by claiming staff are "managing behaviors" during the commute?
A9	Transportation to and from an individual's home is built into the ADH service rate and is not a separately billable activity. Transportation that occurs as part of the program day (that is, transporting an individual to and from a community activity) can be billed as CLS-G.

4.12 PAB (page 199)

Q10	For out-of-state travel PAB and CLS-Ind, if PAB or CLS-Ind are provided, the total of out-of-state days would be subtracted from the ResHab total of 344 and not 365, right?
A10	The ResHab rates are designed to fully compensate a provider for 365 days of care over 344 billing days (that is, the rates are inflated by dividing assumed annual costs by 344 days rather than 365 days so that a provider is fully paid even if the resident is occasionally absent from the home). When the participant travels out-of-state with the ResHab caregiver who is authorized to provide out-of-state PAB and CLS-Ind, the total number of days that our-of-state PAB and CLS-Ind are authorized would be subtracted from the 344. If the participant travels out-of-state without the ResHab caregiver, the ResHab authorization does not change. In the instance of the caregiver taking the individual on vacation and billing PAB and/or CLS-Ind for supports provided during that time, the CM would reduce the authorization by 7 days. Therefore, 344 days – 7 days = authorization is reduced to 337.

Q11	Pertaining to participants that live in licensed homes, when participants go to the hospital, does the ResHab needs to find someone else to provide PAB at this time? If so, is another provider agency able to help support the participant with PAB during this emergency time?
A11	The ResHab caregiver is not responsible to find a PAB worker to support a participant while hospitalized. The case manager should be involved to authorize the PAB by any agency if additional supports are needed while in the hospital. Not everyone who goes into the hospital may need a DSW worker with them, so this is only for those who need to receive the service while hospitalized.

CLS-Ind

Q12	How do we get reimbursed for off island medical appointments especially when they are overnight? Do CMs add CLS-Ind units to their budget?
A12	For medical appointments, that service should be sought through the health plans which are responsible for medical transportation related costs and may provide companion supports.

Q13	CLS-Ind's new ratio options are 1:1, 1:2, 1:3... etc. It says for a workplace, but shouldn't a workplace be IES or DCP? When would that be used? I also would think it be rare that two or more participants are employed at the same business at the same time/shifts?
A13	IES in the workplace include activities needed to obtain, learn, and maintain competitive integrated employment. This includes on-the-job work skills training, instruction to perform the job, individualized problem solving with the participant, etc. 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, CLS-Ind may be provided in the workplace.

	CLS-Ind may be provided in the workplace for 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 work site. CLS-Ind 1:2 or 1:3 is available if needed but is not highly utilized because participants/employees may have varying shifts that do not intersect where one CLS worker could work with 2-3 participants at the same time.

ResHab

Q14	Is it imperative to have an RN as service supervisor for ResHab?
A14	If you have an RN as a ResHab supervisor or any other service for which the RN is bundled in, that's up to the organization to decide. DDD is not making it mandatory that you have an RN as a supervisor. We want an RN to do the nursing assessment and assess for tasks. Then, the RN may delegate as appropriate.

Q15	Once a caregiver is paid the max 344 units, this covers the entire year of 365 days. When a caregiver goes on vacation, and respite caregiver is with another provider, does the CM add additional units up to 365 days, or are they to transfer the units from the caregiver to the respite caregiver? Every agency has a different way of calculating how they pay their caregivers for the 344 days?
A15	The agency is responsible for providing 365 days of care. The rate model fully pays for 365 days of support over the course of 344 billing days. Thus, additional days will not be authorized based on a caregiver's vacation. Agencies need to work with their contracted caregivers to determine how caregivers will be paid and how their vacations are handled, to ensure that the agency has adequate resources to continue to ensure care is provided to the individual while the caregiver is on vacation.

Q16	Clarification, please. Now that nurse delegated tasks are being put back into ResHab services, does the nurse need to provide a quarterly visit (in-person/telehealth) and a quarterly summary?
A16	Yes, oversight and monitoring continue for these services even though they are built back in so the nurse will have to do quarterly visits (in-person/telehealth) based on the parameters in the Waiver Standards. The agency can submit a separate RN quarterly summary, or it can be included into the quarterly summary for the service. Quarterly visits are required, at minimum, but the RN may determine if more frequent visits are needed. If the participant has additional or complex needs, they may require more frequent visits (in-person/telehealth).

1.7.D Nursing Assessment and Delegation (page 47)

Q17	Will T&C RN be required for RN delegated tasks using CD services? If so, which agencies are accepting to do this? No known providers have been willing to do T&C RN for CD services. How is the Branch going to resolve this problem?
A17	The purpose of T&C RN is to address safety concerns and the need for monitoring and oversight by an RN for CD services that include nurse delegation activities. DDD has identified at least one provider who is willing to do the T&C RN for CD Services. DDD will continue to try to build provider capacity in this area.

Q18	Can a provider submit their own nursing assessment to begin providing RN services? Same for annual submissions?
A18	The process previously in place will continue to be used which requires the provider to submit the DDD nursing delegation packet along with the nursing assessment. Nursing assessments designed by the provider agency or other entity are not accepted. The purpose for requiring the DDD nursing assessment is to maintain consistency within DDD regarding the information gathered and documented on the standardized form. The DDD nursing assessment is quite comprehensive and includes much of the components of each provider agency nursing assessment so that can be duplicated if there is a need to have overlap.

Q19	For participants who need T&C, will the 2 hours that nurses used to bill for the assessment be included or will it still be separate?
A19	For participants who need T&C RN, for CD PAB, CD CLS-Ind, CD Respite, Community Navigator DCP, and IES, up to 2 hours may be authorized to complete the nursing assessment. If there is a need for a nurse assessment for other services, the cost of the nurse assessment is incorporated into the service rates and no T&C RN will be authorized.

<u>T&C RN</u>

Q20	Cradles N Crayons has been identified as an agency providing T&C by RN assessment and delegation oversight services. We currently provide this service for another waiver provider.
A20	Noted.

Q21	Just to clarify, T&C RN will be removed to CLS-Ind, CLS-G, ResHab, ARS, and PAB services, correct?
A21	The authorization and the stand-alone T&C RN service has been removed when required as part of the listed services. Instead, the cost of nursing supports has been incorporated into the rates for these services. If someone is receiving waiver service hours during these services and they have nursing tasks that they should receive, a nursing assessment must still be completed. They will either receive RN services from the RN or receive delegated services.

Q22	For most services, there is no more separate billing for T&C RN, correct?
A22	Yes, for most services, there is no separate billing for T&C RN.

Q23	Regarding the RN being built back in during the work group meetings, I thought it was discussed that we can use our own provider assessments if the assessment has the same information as the NPA that DOH provides? Is this still the case or is it mandatory that we use the assessment provided by DOH?
A23	Yes, we did discuss in workgroup meetings. Ultimately DDD decided that because of oversight and data collection purposes, we will continue the current process, which is to use DDD's packets with the assessment. It is mandatory that providers use the DDD nurse delegation packet.

Q24	Since T&C RN service rates are inclusive how do agencies allocate it in the budget report.
A24	The rate models detail the amount of funding included for nursing supports. For example, the ResHab rate model assumes $49.90 per individual per week (about $2,600 per year). As with all rate model assumptions, the assumptions related to nursing supports are meant to reflect typical costs. Some individuals will likely require more nursing support while others will need less (or none at all).

Q25	If a CD participant needs T&C RN, who determines that there are nursing needs? Who fills out the RN 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.
A25	The case manager can assist with this at the ISP level. The case manager can assist in identifying the need for a nursing assessment and a T&C RN provider that would complete the nursing assessment and delegation plan, if needed.

Q26	For those who are already in process of the year for (RE T&C RN) and have hours that are being currently realized, will those billing hours continue through the end of the plan year or will that be changed as of November 1, 2023.
A26	No, authorizations and any remaining hours for T&C RN connected to ADH, CLS-G, CLS-Ind, PAB, Respite, and ResHab will end on 10/31/23.

Q27	With T&C RN, for those hours that are already part of a plan year, will those still be billed until the next plan year (ISP), or will that be cut across the board as of 11/1/23?
A27	Authorizations and any remaining hours for T&C RN connected to ADH, CLS-G, CLS-Ind, PAB, Respite, and ResHab will end on 10/31/23.

Rate Study

Q28	Can we get a link to the new rates?
A28	We will provide the link for the new rates to the CMs and providers as part of the implementation process for these rate changes.

Q29	Can Stephen please explain how the nursing services are built into the rates? How should we allocate/budget for our RN staff given the rate allocations?
A29	Weblinks to the newly updated rate models have been shared. This information shows supports are now being built into the rate. There is a new section of the rate model which is called Nursing Supports. The rate model includes assumptions about the number of service recipients per nurse, recognizing that not all individuals require nursing services.

Q30	I didn't understand Stephen's answer regarding ResHab and caregivers going on vacation. If the caregiver goes on vacation and the participant stays with someone else from another agency, who pays the ResHab rate? Are the number of days subtracted from the 344 and given to the other agency?
A30	If the participant stays in another home with a different ResHab agency, the ResHab authorization is reduced for the original agency and an authorization is issued to the temporary/substitute agency for the equivalent amount that was reduced.

Q31	With the new rates as of November 1st, will new authorizations be generated?
A31	New authorizations will not be generated.

Q32	Will rates change online to reflect the additional increase beginning 11/1/23.
A32	DDD is working with Conduent to get everything in place for these new rates to begin on November 1st. CMs and providers will be notified when claims can be submitted at the increased rates.

Q33	How does the rate study view RBT PAB and CLS-Ind services/staff? The wages for RBTs have increased quite a bit and this doesn't seem to be taken into account.
A33	DDD did not establish rate models for RBT services. Instead, the rates were benchmarked to other programs. As a result, there are not cost assumptions to update as there are for services with rate models. DDD does intend to evaluate RBT rates as part of a rate study to be conducted in 2024.

Q34	Why was there a significant drop in the rate for AFH ResHab Tier 2?
A34	The 2020 rate study created separate rates for ResHab services provided in licensed homes and in Adult Foster Homes (AFHs), recognizing differences in these service models. For example, the rate models for licensed homes assume that the homes have paid 'shift" staff, while the rate models for AFHs assume that services are provided by the foster caregiver without other paid staff. As a result, rates for AFHs are somewhat less than the rates for licensed homes. Please note that DDD is not reducing any rates at this time.

Q35	Is the 2-hour RN assessment already included in the rate increase?
A35	As it relates to those services where the nurse delegation is bundled into the rate, that amount is all-inclusive. Those costs are reflected in the rate models that will take effect on November 1, 2023. We don't break the rate out in terms of the specific tasks or even the number of hours in total that a given participant is going to receive. The rate is really based upon the population model that says for every X number of individuals receiving a given service, the agency needs one nurse to handle nurse delegation tasks, but also recognizing that some individuals get delegated task or need delegate tasks, and others do not. So, the rates include everything that is going to be included for the service. It is a bundled rate. We will look at the cost closely through the next rate study. Specifically for Maui and wildfire response and the declared public health emergency, Maui County participants did begin to see those rate increases in August 2023 as stated in Appendix K. We addressed this rate change just like we did during the COVID-19 pandemic to allow us to move forward with several flexibilities as well as to be able to do some temporary rate increases. For service delivery, Maui providers are receiving a very limited retainer of 125% of what the fee schedule would otherwise allow. For example, if the rate was $10 per quarter hour during this Appendix K period, it will be reimbursed at $12.50. Please note that this is not targeted specifically to nursing and we're not making any adjustments for individual components of the rate. We're just saying that we're adding a 25% temporary rate (TR) adjustment for all services delivered in Maui County.