Waiver Amendment Public Information Session

Welcome to today's Developmental Disabilities Division Waiver Amendment Public Information Session.

My name is Stacy Haitsuka. I'm a member of the Developmental Disabilities Division training team.

My office is located on Oahu in Pearl City, and I'll be helping to facilitate today's webinar.

Today's webinar is being recorded.

I will let you know when the recording and the handouts are posted to the DDD website. So, thank you for your patience.

Before I introduce our first presenter, I'd like to explain how we will address your questions and comments.

While the presenter is sharing their information, your microphone will be muted.

There will be time for questions… and comments at the end of the presentation.

So, to ask your question or to share a comment, you should use… the Zoom tools.

You should either see them on the top of your Zoom bar, or at the bottom (it just depends what device you're using).

To verbally ask a question, you can raise your hand… using the hand icon.

Or… to type your question or your comment, you can select the Q&A feature… on the Zoom toolbar, and you can type your question into the text box. Okay.

Alright… Great! And, welcome again to today's… Waiver Amendment public information… session.

I will now introduce our first presenter, Mary Brogan.

Mary is the administrator for the Developmental Disabilities Division.

She will explain why we are doing… this public information session.

Mary?

Mary: Thank you Stacy! Good morning everybody… across the state. Thank you so much for joining us.

This is the Waiver Amendment Public Information Session.

Any change to the waiver-- either Waiver Amendment or Waiver renewal requires a public comment period to allow participants, families, providers, and other stakeholders the opportunity to provide input, or comment on the proposed changes.

The state considers the public comments for additional changes to the waiver or waiver amendment.

This waiver amendment public information session is to share the proposed changes... to the Waiver and to kick off the public comment period.

Okay. DDD is applying for a Waiver Amendment to be effective January 1st, 2026.

This... Waiver Amendment is to implement the increased rates from the 2024 rate study to coincide with the increase in minimum wage-- which also goes into effect on January 1st, 2026.

The rate study proposed rate increases for the rate study proposed rate increases for most services.

These services were PAB, ResHab, additional residential supports, adult day health, community learning services, community navigator, discovery and career planning, individual employment supports, Respite, Chore, non-medical transportation, private-duty nursing, and training and consultation.

Also, the ranges within individual supports budgets were revised to correspond with the increased service rates to ensure participants can access the same amount of services.

As well... the maximum cost for vehicle modification is also increased--based on an analysis of the trend of higher costs for vehicle modifications over the past two years.

At this point, I'd like to introduce Stephen Pawlowski... consultant to DDD from... Burns and Associates (HMA), who's been... working with us... over the years on rate studies. And... thank you Stephen!

Stephen: Great! Thank you, Mary. And, good morning everybody. As Mary said...

I am Steven Pawlowski. I'm with the Burns and Associates' Division of Health Management Associates.

We're the consultancy that's been working with DDD for the better part of a decade now on a variety of topics... primarily around provider reimbursements.

However, we've also been involved in the development of Individual Supports Budgets and tying those to the Supports Intensity Scale, previous Waiver Amendments and renewals, and other similar related tasks.

I'm going to do the bulk of the presenting today-- because this waiver primarily involves the implementation of the rate study that my team and I conducted in 2023 and 2024.

In terms of the specific topics that I'm going to walk through...

I'll reiterate really what Mary just told you in terms of the contents of the Waiver Amendment.

But then, because (as I said) the amendment is primarily focused around implementing that 2024 rate study, we'll spend some time providing a refresh on the background, the approach, and process-- as well as the recommendations that came from that rate study.

I will note that most of my presentation here this morning is going to be relatively high level.

For example, we're not going to walk through the rate models themselves. That being said, those models will be re-posted, and there's other material out there (when we last sought public comment as part of that rate study process).

So, with that, I'll move into the first section of the agenda-- which (as I said) is a summary of what is included in this Waiver Amendment that... the Department of Health, and the Division of Developmental Disabilities expects to be submitting to CMS here in the coming months (for an approval effective January 1st, 2026).

As Mary said, there's really three broad issues covered by the Waiver Amendment request.

Two of them relate to the rate study.

And then, the third relates to vehicle modifications to make sure that remains accessible and effective for those folks who need that particular Waiver support.

As I've said a couple of times now, fundamentally the Waiver Amendment is designed to allow DDD to implement the recommendations that arose from the rate study that we wrapped up last year.

For those of you who really like getting into the details of the Waiver itself (the 260 to 280 page document), on this slide, we've told you where the major changes in the application are being made.

So, the rate study methodology is described in Appendix I2A.

And then, because the rates are increasing,

DDD also had to update the financial projections that the federal government, the Centers for Medicare Medicaid Services (or CMS) require.

And, that's going to be included in appendix J and more specifically in year five of that five-year forecast.

Additionally, as with every previous rate increase, DDD is also updating the Individual Supports Budgets.

The intent there is to ensure that the level of supports that individuals have access to is not reduced because of the rate increase. Right?

So, if someone has a budget of say $40,000 and rates are going up... that means if we don't increase the supports budgets (or ISBs), the individual will be able to buy fewer units of service.

So, that $40,000 needs to be increased to the amount that allows the participants to receive the same level of support they're receiving today.

So, this is really a mathematical exercise. We have underlying assumptions about what services are included within each ISB. And, as the rates are adjusted, we always (or DD I should say) always... updates the ISBs to make sure that the... they continue to reflect whatever the current rates are going to be.

So, there's no other changes being made to the ISBs. This, as I said, is simply a mathematical exercise to reflect the increase in the rates.

The process for setting those ISBs originally (which is pretty interesting)...as well as the new ISB amounts (themselves) are included in Appendix C4A of that big Waiver Amendment (or the big application).

And then, finally, the third element (which is outside of the rate study, strictly speaking) is an increase a near doubling of the limit for vehicle modifications.

As Mary already said, DDD has been tracking the requests and costs of modifications that go through the Waiver and those costs have increased pretty significantly since this current $36,000 limit was established.

DDD wants to ensure that the service remains viable-- that those folks who need a modification have access to what they need.

So, the limit is being increased to $70,000.

Now, that's not to say that it will always be a $70,000 expense. This is the maximum that can be approved.

But, it provides more flexibility to ensure that the modifications that are (at times) required can be accommodated through the Waiver.

And again, for those folks who want to look at the Waiver Application itself-- that update is covered in what's referred to as Appendix C1-C3 under the vehicle modification service.

So, from here, I'm going to take a step backwards and provide a little bit more of an overview about how we got to this stage. So, we're going to begin with the background from the rate study.

As I said, I want to keep this at a relatively high level… because we've previously presented the rate study results… just last year.

But, in terms of why this rate study is being conducted, the services provided through what Mary and I have been referring to as a Waiver is really a Medicaid waiver… that allows states to cover a variety of Home and Community-based Services.

The federal government who approves these waivers has a lot of rules around them (unsurprisingly)… and one of the rules relates to how much providers get paid for delivering services.

For all services covered under Medicaid (whether that's a waiver service or what we call a state plan service), you can think about those as the type of services that are delivered through the MedQuest health plans.

There's a federal statute that requires payments to be consistent with efficiency, economy, quality-- and for them to be sufficient to enlist enough providers so that folks have access to covered services.

For Waiver programs in particular, there is additional federal guidance that direct states to conduct a comprehensive review of their payment rates, and their payment rate methodology at least every five years.

And, in addition to that, there is the expectation i(n this federal guidance) that the rates themselves be transparent, that the rate setting process allow opportunities for public comments, and that the rates that are ultimately established are based upon defensible and… market-based data points.

Consistent with this federal direction, DDD has conducted rate studies around every four to five years here over the past decade plus.

And, myself and my team have been involved in those previous rate studies that occurred in 2015 and 2016 as well as in 2019 and 2020.

I'll also note that those previous rate studies have been implemented (just like the 2024 rate study is now going to be implemented)-- which I think really speaks well to the partnership between DDD and the provider community as well as other stakeholders resulting in buy-in from both the executive branch and the legislative branch because… each of these rate studies have required significant additional investment within the system.

The next slide covers a little bit about my organization-- to let you know why it is you're listening to me talk here for the next 30 minutes or so.

So, Burns and Associates is a health policy consultancy.

We work almost exclusively with state Medicaid agencies and their sister agencies (the IDD departments), as well as behavioral health authorities. So, all of the agencies that are responsible for delivering Medicaid-funded services.

Since Burns and Associates was founded back in 2006, we've consulted to about 30 states, and in about half of the... country (so about 25 or so states).

We've consulted specifically to the state Developmental Disabilities program-- whether that's DDD in Hawaii or the... the corollary in many of the other states across the country.

We sold our company (Burns and Associates) to a larger consultancy in 2020 (Health Management Associates).

And so, that's why you now hear me refer to my firm as "HMA Burns". It...

Burns remains a division within HMA. It's still the same staff working with the same clients doing the same work, but we're under a different corporate umbrella now.

Really, almost since our founding, a specific emphasis of our firm has been the Intellectual and Developmental Disabilities or I/DD field.

And, within that space, we do an awful lot of different things, and... we've done a lot of this work in Hawaii (as an example) over the decade plus that we've been consulting to DDD.

And, it ranges really from policy development work on the front end-- helping establish service definitions (or even brand new waiver programs)-- all the way to the evaluation of the effectiveness of programs.

And then, pretty much everything in between. We do an awful lot of rate setting-- including (as I've said now) three rate setting projects here in Hawaii.

We also get involved frequently in the adoption of assessment instruments like the Supports Intensity Scale in Hawaii, and using the results of those assessments to inform individualized budgets.

So, from here, I wanted to talk about the approach that we employed for this particular engagement.

So, as I said, Burns has been doing projects like this since our founding, really.

I myself have led dozens of rate-setting projects that are very similar.

And as a result, we have a standardized process. Now, the results are of course always customized to the state's needs,

But, in terms of how we go about setting rates for Home and Community-based Services, we have… a pretty standard… playbook for that.

We have coined the term for our approach "an independent rate model approach or independent rate setting".

And, what we really mean by that is… we're not dependent on any single source of information.

In the middle of the slide, you'll see that we talk about the various resources that we use when we're evaluating the sufficiency of payment rates.

We always begin with a comprehensive review of program requirements. So… looking at statutes, or regulations or policies, or any other documentation that talks about what the state's expectations for the services are.

We also endeavor to incorporate provider and stakeholder input throughout our process. And, I'll talk about… those specific steps later in this presentation.

We supplement data that we gather from providers (and other stakeholders) with independent published data sources-- like wage estimates from the Bureau of Labor Statistics or the IRS's standard mileage rate.

And then, as appropriate, we'll conduct special studies-- like benchmarking rates for one state against other programs or what other states pay.

The first bullet on this slide actually kind of encapsulates our mission statement when it comes to HCBS rate setting-- that we want to build rates that reflect the cost that providers incur… to deliver services consistent with the state's requirements, and an individual service or treatment plan. So, the state defines the service.

ISPs dictate what individual supports providers are supposed to be delivering to a given individual.

And, we want to make sure that the rates that providers get paid for delivering those supports is consistent with the cost that they incur to do so.

On the next slide, we talk a little bit more about the rate model aspect of this work.

And so, when we're building rates, one of the things that I always want to make sure my audience hears is that we're just not telling folks that we think a rate ought to be $40 per hour.

We're going to outline exactly what we think are the major cost drivers.

So, we're going to show… how much we're assuming for things like the wage paid to the direct support professional or other care provider.

We're going to show what we're assuming are the benefit expenses or the agency's overhead costs and the like.

We have to make those assumptions in order to get to a bottom line.

But, for the providers in particular on this phone call, we always emphasize that those assumptions are not meant to dictate… the provider's operations. We expect that for any given provider, some costs will be lower than we've assumed, and other costs will be higher.

And, the compensation for a direct support professional is a good example of that.

For a given agency, their staff might value higher wages than we've assumed, but put less of an emphasis on benefits.

So, maybe within that provider organization, they pay more than what we've assumed, but the benefits are less comprehensive than what's built into that cost.

That's all okay. Again, we're trying to build rates that reflect those typical and reasonable expenses.

But for any given provider, we know that there's going to be some variability.

The other thing that we also want to emphasize is that when we're talking about rates for a service, oftentimes it's not a rate for a service, it's multiple rates for a given service.

And, you might have multiple rates for a single service for a variety of reasons. And in fact, I think yes, all of these apply in Hawaii.

First of all, if you have different assessed needs at the individual level, rates might vary.

And, in fact, for things like ResHab and ADH and… CLSG, there are different rates (based upon the level of need of the individual as determined by the CIS).

And, that's because we recognize that supporting people with more intensive needs requires more intensive staffing (lower staffing ratios, for example). And, it's more expensive to operate a program at say a 1:3 ratio, than it is to operate at a 1:6 ratio.

Additionally, rates can vary based upon the location of service delivery.

And so, for generically-defined day programs, we have Adult Day Health rates (which are center-based), and we have higher rates for Community Learning Services (or CLS group services)… delivered in the community to recognize that… staffing typically needs to be more intensive out in the community.

You have lower productivity-- because you're having to drive between the individuals that you're providing care to… and similar types of factors.

We also will sometimes vary rates based upon geography. That's been one of the… key recommendations from the very first Rate Study that we conducted back in 2015… is that

we established a different rate schedule for the Big Island versus the other islands... to recognize the larger travel burden on the Big Island.

In other words, it takes providers longer to get to the people they serve because, as the name suggests... the island is larger and it... and it covers more ground.

And then, finally... rates might vary based upon staff qualifications and training.

So, we talked about private duty nursing... in Mary's introduction. So, we have different rates for services delivered by registered nurses versus licensed practical nurses to reflect the... fact that wages for RNs are higher than wages for LPNs.

On the next slide, we provide [an] illustration of the major components of a rate model. So, I spent a minute... on the previous slide talking about we don't just produce a rate of $40. We actually show you... all the assumptions that we're making.

For most of our HCBS rate models, there's going to be five factors that are included in nearly all of them.

Three of them relate to the direct care worker-- and that's how much they're paid, what their benefit costs are, and what their productivity is. And, in other words, the number of billable hours of service that they're able to deliver during their work week.

And then, two of them relate to the agencies' overhead expense which we divide between program support and administration.

There might be other factors-- depending upon the specific service that we're evaluating.

So, if we're talking about a shared service like ResHab or ADH program, we'll have assumptions related to staffing ratios, and absent... absence rates for... service recipients.

If it's a service that occurs in the community, we'll include things like transportation or vehicle related expenses.

Sometimes we'll include things like program facilities and supplies. This is not meant to be a comprehensive listing.

It's meant to provide an illustration of the types of things that we'll incorporate in a rate... depending upon the specific requirements of that service.

We always like to wrap up this overview on the next slide by talking about what we see as the primary benefits of this approach.

First and foremost, we endeavor to be transparent.

We understand that folks don't always agree with all of our recommendations, but... we at least want individuals to understand how we arrived at those figures.

So, as I said a couple of times now, when you look at the rates that will have been posted online and that will be re-posted after this meeting, you can see exactly how much we built in for things like the… direct support professional wage or the agency's overhead rates.

Again, folks may not agree, but you're going to know how we got to that bottom line. And… furthermore, really throughout the whole process of setting rates, we try to be transparent. We share results of the provider survey that we conducted.

We'll have an opportunity… we had an opportunity for public comments even in advance of this meeting.

And, we have similar… steps throughout our process to gather inputs and to let folks know how it is we're progressing.

When we have detailed rate models, that allows us to… also do things like advance policy goals and objectives.

So, for example, if the state wanted to increase training requirements, you could pull the number of hours that we have assumed in the rate model out, and put a new number in, and the rate models will automatically recalculate without having to go through a long time consuming and costly rate setting process.

Similarly, the rates themselves can be maintained over time to account for changing expenses.

And, this has actually been a key feature… that we've taken advantage of here in recent years (even before the 2024 rate study).

And so, for providers… but others… that follow the labor market in Hawaii, you'll recall that there have been actually a series of minimum wage increases… even prior to the $16 an hour that's coming here in the next 6 months.

And, as minimum wage increases, we need (or believe that we need) to increase the amount that providers are paid-- because we don't think that DSPs are minimum wage workers.

But, we know that there are other opportunities that DSPs have to work in other fields. And, as the minimum wage goes up… in order to remain competitive, we believe that Waiver service rates need to be increased as well.

And so, using first federal funds and then after those federal funds… ran out… available state funds, the state was able to increase payment rates previously… (a couple of times actually) to accommodate each step in the minimum wage increase.

So, as minimum wage has gone up, there have been increases in the rate models because again they're detailed in such a way where we could pull out an existing wage assumption and update it based upon the modeled impacts of an increase in the minimum wage.

And so for example, the last rate increase... I believe occurred back in November of 2023.

And, that was to accommodate the rate increase... excuse me... the minimum wage increase that followed in January 1 of 2024.

So, having the... this really detailed rate model structure in place (which we first established back in 2016)... has allowed for... DDD to communicate the needs for additional investment in provider reimbursement over the years and be pretty effective in... ratcheting up rates (as necessary) several times here over the past decade.

So, that covers our approach. We'll now talk in a little bit more detail although still keeping it high level about the process that we used for this rate study.

And so, this slide is how I illustrate the major phases and tasks that we include in each of our projects.

Phase one (which is colored in blue) is the work that we do... to do background research and really understand the system in which we're working-- which is really very critical because although we've done rate setting projects for I/DD services in about 15 states now, every single state is unique.

And so, the rate models that we built in Maine or Mississippi or California or any state in between are not necessarily going to be appropriate for Hawaii.

It really is incumbent upon us to understand the unique characteristics of each state in which we're working.

And so, that's what we're really trying to accomplish in Phase 1.

Phase two, which is more of a... I don't know, not quite turquoisey... I guess a blue green color in the middle of the slide, is the data collection phase.

That's both primary data collection where we're gathering information from service providers, as well as secondary data collection where we're relying upon other published sources of the kind that I mentioned earlier in the presentation.

Those work streams come back together for Phase 3.

And, that's where we're actually building out our recommendations, developing our rate models, providing an opportunity for public comment, and ultimately finalizing those recommendations.

I have a couple of slides now that go into a little bit more detail about each of these individual tasks.

So, as I said, Phase 1 is doing the background research, and I've already covered that. That includes things like… evaluating existing statutes and regulations and policies, reading the Waiver Application (for example). And then, we also compile existing payment data. So, we look at… trends that we're seeing in the claims and the relationships between services and service volumes.

We then always like to supplement what we're doing by reading the words on the page or doing the claims analysis by having conversations both with the state team, as well as as system representatives.

And so, we have a number of meetings with DDD where we're peppering them with questions about the service requirements and… the interpretations.

But then, we also have meetings with a typically provider advisory group.

And, that's what we did in this project as well-- where we had a group of providers that we convened (I don't know three or four times during the project at key stages) to get their input and feedback-- because they're the folks that are living service delivery day in day out and they're able to best speak effectively to what's working well in the system, what's not working well, where they would recommend changes and the like.

As I said… in the next phase, we're beginning our data collection that includes a provider survey.

That provider survey (as providers who participate can attest) is involved.

We're asking not just for financial data, but also for information about how services are delivered. So, things like… what are staffing ratios like, what is the productivity of your staff? In other words, how do they spend their work week?

How much of it's divided between billable time versus non-billable time?

How many miles are staff driving on a weekly basis or monthly basis?

And so, it's very comprehensive. We give providers more than a month to ultimately complete it and submit it to us.

And throughout the process, we provided technical assistance through things like… recording a webinar, providing a dedicated point of contact, and then we include instructions and guidance uh that accompany the survey.

For our 2023… 2024 survey, we received completed surveys from about a third of the provider community-- 20 out of 59 providers, and they accounted for about a third of spending in fiscal year 23.

So, a reasonable response rate. We always would like to see it a little bit higher, but we still felt pretty good… about the data that we received from… the 20 providers that… submitted a survey.

We conduct.. an in-depth evaluation of the submitted data.

We follow up (as necessary). And then, we presented the results to the provider advisory group to get their feedback. Is there anything that looked... (for example) unusual to them, or they thought might be unreliable?

In addition to the survey, and still part of task two however, we conduct other research and analysis-- and that's on the next slide.

That includes things like evaluating independent data for key-cost drivers.

I've made mention of a couple of these already. So, we use the Bureau of Labor Statistics or BLS... to gather Hawaii specific wage data.

We're looking at Hawaii-specific health insurance costs reported through... the Federal Department of Health and Human Services Medical Expenditure Panel Survey.

We use the IRS's mileage rates... and a couple other similar data sources.

Additionally, we did a review of payment rates paid by other programs for similar services.

And then, not included in this slide, we re-evaluated the efficacy of having the Big Island based rates.

And, I'm going to come back to that point... when I get into our recommendations.

So, that then takes us to the final phase of the... rate setting process, and that's developing our recommendations.

So, we drafted rate models.

As I'll talk about a little bit more in my last couple of slides, we primarily updated what was already in place. So, we already built rate models in 2015 and 16-- which was kind of a significant change to how services are reimbursed in Hawaii.

We updated those, and made some other changes in 2019 and 2020 (actually, a good number of changes).

In this most recent rate study, we made fewer structural changes. So, the models themselves... didn't change very much. What changed was the cost assumptions, right? We needed to take into account rising expenses.

Then we had a public comment process where we posted our proposed rate models and supporting materials like the provider survey results.

I think we did a live webinar, but we also (I believe) recorded a webinar, and posted it online to explain those proposals.

That public comment process resulted in very, very few comments actually being submitted to us.

We took that to mean that folks were generally satisfied with what our recommendations were. We... hope that was the case. But, as I said, relatively few comments were actually submitted.

So, that then took us to the final task here in Phase 3-- which is finalizing the rate models.

So, the materials have... were previously published online.

They're going to be updated (as I understand it) in the next day or two after this meeting so folks can refamiliarize themselves.

But... the rate models, themselves, had been previously published back in July of 2024. So, almost exactly a year ago now.

We had already... provided an opportunity to comment on the specific rates themselves (if folks were satisfied or not).

So, it's not new material. it's just going to be re-posted-- so that it's... again in a place where you can quickly find it.

From here, now, the focus has really been on implementation support.

If we can just back... back up for a moment or... two.

So, one of the things that we're also tasked with is estimating the fiscal impact.

Generally speaking, DDD doesn't have money lying around to increase payment rates.

So, one of the things that we provided assistance with... is estimating how much more it would take to implement these rates, and then, developing the justification to go through the state's budgeting process. And, that was successful.

So, the department and the governor's office supported... a request to increase provider rates that was included in the legislative budget that was ultimately signed by the governor-- which is why... DDD is able to now begin implementation of the rates here at the beginning of calendar year 2026.

And then, perhaps obviously (because we're in this meeting), we've also updated the ISBs, and we continue to provide assistance in developing the waiver amendments.

Now, I'm going to wrap my comments up by hitting the highlights of the recommendations that have been included in the rate study.

Again, this, as I've said a couple of times in my remarks, is meant to be... fairly high level. There's more detailed presentations or the rate models themselves... separately available.

But I did want to remind... those of you listening to today's webinar about the major recommendations from this 2024 rate study.

As I mentioned, we're primarily building on the existing rate models.

So, you know, as an example, previously we took the ResHab rate… and we divided that between group home type models versus adult foster models. That's a pretty significant change.

In this most recent rate study, we're really just taking the rate models as they are… and updating the expense assumptions more than anything else.

I said I was going to come back to the issue of island-based rates. And so, I mentioned that a big change that we made in 2016 was establishing two fee schedules, one for the Big Island and one for the other islands.

As part of this project and… drawing on feedback that we've received from providers over the years, what we have decided to do (what DDD has decided to do) is to apply that higher fee schedule not only to the Big Island-- but also to Maui… and Kauai. And, in other words, the islands outside-- and so Molokai, Lanai… as well the islands outside of Oahu.

And, we did that based upon [an] evaluation of enrollment, and what that translates to in service volume.

The reality, which is not a surprise to anyone listening to this call, is that there's just fewer people on the islands outside of Oahu.

But, providers have certain fixed expenses that they have to cover-- regardless of whether or not they're able to serve 100 people or 10 people.

And so, we believe (and DDD believes) it's just reasonable to have… that higher fee schedule for… the islands outside of Oahu to reflect the fact that there is a lower service volume, and hopefully, build some of the provider capacity.

Even when we look at individual services like… residential options (outside of Oahu), oftentimes there's very few.

If we look at things like day programs on some of the islands, there's only a handful of day programs in operation. So… we want to make sure that the… delivery of services outside of Oahu remains viable. And as a result… we're applying that higher fee schedule to all of the islands outside of Oahu. So,… we continue to believe it makes sense to have two fee schedules.

But now, it's Oahu versus all the other islands. And, all the other the rates on all the other islands are… somewhat higher than the Oahu rates. Again, to take into account that there's just fewer people there and therefore fewer opportunities to generate revenue outside of Oahu.

Another change that we made that has kind of… ping-ponged back and forth over the years is how we're handling nursing-related supports that are part of service delivery.

So, not the private duty nursing where… it's the nurse that's working directly with the individual for… you know, multiple hours on end.

These are things like nurse delegation… or clinical oversight of programs.

Originally, we had those expenses built into the rate models. Then, they were pulled out and the … guidance was that training and consultation ought to be billed directly for things like nurse delegation.

Again, drawing on feedback from providers (and there were actually quite a number of working sessions that DDD clinical staff facilitated), the decision was made to bundle those expenses back into the rate models themselves.

And so, when you look at the actual rate models for PAB, ResHab, ADH, CLS, and Respite, you'll see line items in there for nursing-related expenses.

So, those costs for things like delegation and clinical oversight are now bundled in to the underlying rate. So, nothing different has to be billed for them.

It wouldn't be billed through TNC. It's now a component of the listed services-- which again… that's not brand new.

That's the way things had been after the 2016 rate study. In the 2020, we un-bundled it. Now, we're bundling it back in.

Couple other highlights that I wanted to cover… include the direct support professional wage assumptions.

And, I maybe could have led with this… because this is the single largest driver of the rate increases that we have recommended-- which isn't a surprise for two broad reasons. The first is that's the single largest expense… that providers incur… is paying the staff who are delivering services, right?

It's not like… hospitals where the expenses are things like the building and the equipment and the prescription drugs that flow through the hospital… as well as doctors and nurses, but the cost of a hospital is much less payroll and much more those other expenses.

Whereas, when we're talking about Home and Community-Based Services, the primary expense really is on the staffing, the payroll side.

And so, we've spent a lot of time over the years thinking about setting reasonable wage assumptions for direct support professionals.

Couple of changes that we've made in the 2024 Rate Study… is standardizing those wage assumptions across services.

If you look at the 2020 rate models, there are minor variabilities. The wage assumption for folks who work in RESHA have are a little bit different than the wage assumptions for folks who work in day programs ADH and CLSG.

As part of this rate study, we wanted to take the position that a DSP is a DSP is a DSP… regardless of the environment in which they're working-- whether that's in a residential environment, an in-home environment, or a day program environment. So, now it's the same wage assumption across all of the DSP driven services.

Additionally, as Mary mentioned in her opening remarks, we made adjustments to the calculated wages based upon the coming increase in the minimum wage.

Again, I want to emphasize a point that I raised earlier is that we are not saying that we believe that DSPs are minimum wage workers. We do not believe that.

However, we understand that as wages for other occupations go up, the DSP wages also have to increase in order to remain competitive.

And so, because this is an issue… that occurs in quite a few states across the country, we've developed our own… methodology to model the impact on non-minimum wage workers as the minimum wage increases. And we… employ that methodology to update the wage assumptions. All that being said, the ultimate result is… the rate models are now predicated upon an assumed wage… for direct support professionals of $21.33 per hour--which is a pretty marked increase from where we started back a decade ago.

But, that reflects inflation. It reflects the… impact of the rising minimum wage.

And, it reflects the commitment that DDD has to supporting a high-quality workforce.

There's other initiatives that remain underway that are not a part of the topic of today's meeting but there is ongoing conversation…with DDD about a… DSP credentialing program that would ultimately… result in further increases to provider reimbursement.

So… it's again… I bring up only because that is… reflective or indicative of the commitment that DDD has to ensuring that there are competitive wages offered for direct support professionals.

And of course, wages are not the only thing that matters. So, in addition to that $21.33 per hour, the rate models also have built-in comprehensive benefit assumptions. So, paid time off is assumed for all direct support professionals.

We assume that all DSPs have access to, not necessarily participating in, but access to health insurance.

And, there's other... similar assumptions built into the rate to provide an attractive benefit package on top of this $21 plus hour wage assumption.

Similarly, we adjusted the assumed payments to adult foster home providers.

So, the way AFH's work (as I think most people listening probably understand), is that the state contracts with an agency... the agency subcontracts with a home provider, and the terms of that subcontract are largely left to the agencies themselves. They're the ones... who set the terms and conditions of the service itself.

But, the rate models still have to include an assumption about how much gets paid. Now... it's not a requirement. It's not a dictate. And in fact... agencies frequently pay an amount that varies from what's built into the rate model. So... it's... not DDD's relationship.

They're not the employer or the contractor, but the rate models themselves have to reflect an assumption.

And, because we had not increased that assumption in some time, we actually bumped up the assumed annual payments to AFH home providers by $10,000 per year.

Additionally, one of the things that has also been proposed is that... we set a floor for how much agencies pay their contracted homes.

Again, it's not that DDD is going to dictate the specific amount, but the department and the division does have an interest in making sure that most of the money goes to the providers-- because they're the ones that are ultimately delivering care to individuals.

And so, in particular, what we have recommended... is that at least 60% of the agency's payment gets paid to the home provider.

So, let's assume that the rate's $100-- which it's not, but at least makes the math easy on me.

If the rate was $100, the agency would have to pay at least $60-- 60% of the total to their home providers.

They can keep the other 40% (or $40) for their own cost (training and supervision and administration and the like)... but at least 60% of whatever that payment is would be paid to the home provider under our proposal.

So, I've talked for an awful long time before I've gotten to the bottom line.

And so, the bottom line you'll see listed here, is that the recommendations from the 2024 rate study increase the overall reimbursement to providers by about 24%. So, pretty significant.

And, as a result, that funding had to be approved through the state's budgeting process. And so... the division wrote a justification. It got approved by the department, and the governor's office and ultimately the legislature... and was signed into law-- which is what allows... DDD to now move forward with this waiver amendment. If the additional funding had not been appropriated, DDD could not move forward-- because they don't have the spare resources lying around.

And, it is a pretty significant commitment to make these investments and provider reimbursements. So, certainly... I believe the it's safe to say we're all grateful to the support from both the executive and legislative branches for this investment.

I think it's also a testament as I mentioned earlier of the partnership between DDD and the stakeholder community that folks came together and were speaking with a... unified voice in terms of communicating the importance of this rate increase.

My very last slide is just a refresh of... another key element of the rate study. So, this is... one of the other major changes made way back in 2016-- and that's moving to tiered rates where the tiers are based upon the results of the supports intensity scale (or SIS assessment).

And so, as the slide says (for mostly shared services) there are differentiated rates (based upon level of need).

So, if you're providing support (say Adult Day Health Services) to someone with significant needs you get paid more... than a provider who's providing support to someone with less significant needs.

Same thing is true for RESHAB-- both the... like the DDOM and ARCH facilities, as well as AFH's and the CLS group service.

In particular, although this isn't the focus of the conversation because this is not changing at all.... another one of... DDD's contractors used the SIS results to assign people to one of seven levels.

And then, for the purposes of reimbursements, we collapse those levels into three rate tiers.

And, you can see that crosswalk on the table on the bottom right part of the slide.

So, the 2024 rate study doesn't recommend any changes to that seven level three tier framework, but it's such a... now integral part of the overall payment model that I wanted to reiterate... that those tiered-rates are in effect and remain in effect in the 2024 rate study.

So, that walks through the rate study and... provides again a refresh. We we wanted not to take up a lot of your time because... we already had a public comment process on the rates themselves last year.

But we wanted to remind folks of what the components of that rate study were.

And then, as we talked about the... ISBs, the individual supports budgets are being increased to reflect the higher... rates as well.

With that, I think I'm going to turn this back over to Stacy.

Stacy: Thank you very much, Stephen. That was a lot of information that you covered.

And, I know... folks have... need some time... to... think about... this information-- how it might affect them.

What we would like to do is... share information for how you are able to submit your public comments.

On this slide... it gives you information... about how to submit... your public comments.

So, please note the dates-- public comment period is between July 18th and September 2nd.

So, you have a lot of time... during that period... to... talk to... your colleagues... to... discuss.

And, maybe... you... have additional comments. You're welcome to submit more than once.

Please email... doh.dddcrb@doh.hawaii.gov, or you can submit it in writing... via mail... to the address on your screen.

We are going to go over some of the questions that have been submitted in the Q&A (in the Zoom Q&A tool). But again, where you would want to submit... the comments going forward after today's webinar... is through these options on your screen.

Okay. The... public comment period again is starting... the 18th... and ends on September 2nd.

You see there that you need to submit it by 11:59 p.m. on... September 2nd. Okay.

Alright. We will start with the questions. Give me a second to scroll up.

Alright. First question. Oh, and before I start questions, let me just make a... quick introduction-- Wendie Lino is here (on the screen). She is the branch chief for the Developmental Disabilities Division, Community Resources Branch. Okay.

Alright, our first question... "What are the specific impacts on the Developmental Disabilities Division waiver funding and services given the passage of Trump's big beautiful bill cutting trillions of dollars from Medicaid?"

Who would like to answer that question?

Well, it's a shame that Mary had to jump off for another meeting. [Laughing]

David, do you have any... anything on...

Stephen: So the... I believe it's fair to say the short answer is the impacts are not direct.

And so, for those following the coverage of HR1, the... federal budget (or the One Big Beautiful Bill Act) the changes being made to Medicaid affect primarily the expansion population. So, the adoption of re-determinations and work requirements (six-month re-determinations and work requirements)-- there's changes to how certain states (including Hawaii) finance... Medicaid programs through provider taxes.

And, there are... other changes for providing services using state dollars to people who are un-documented.

And, obviously there's... other adjustments above and beyond what I just summarized.

None of those specifically impact Home and Community- Based Service Waiver Programs (like we're talking about here this afternoon).

What they do, however, do... is put pressure on the states. And so, Hawaii as well as the other 49 states are going to have to make decisions about how to address the... (as the commenter said)... trillions of... or hundreds of billions (at least) of dollars of cuts being made to Medicaid.

And so, there could be indirect impacts on the Waiver-- as the state has to make hard decisions about how to... either back-fill federal cuts or make other adjustments to their Medicaid systems.

Participant: Alright.

Stacy: Okay. Jessica has a question. She's raising her hand. So, I'm going to... allow her to un-mute... to ask her question. So... OK.

Jessica: Okay... sorry!

Stacy: No problem.

Jessica: Getting used to this workplace thing. So, I have... quite a few questions. Thank you so much for presenting.

My first question is... what is the rate of staffing and retention from the providers... (that you had said you had done the provider kind of survey)?

Are they adequately staffed and what's their retention rate?

Stephen: I don't have the answer at my fingertips. As we get through the meeting, I can share what the turnover rate that was reported through the provider survey was.

In addition to that, there's going to be more current data... that gets reported through the National Core Indicators State of the Workforce Survey (I forget what they... they've changed the name on me) but that... Hawaii providers also participate. And so, I don't have either of those at my fingertips. But, we can probably get those to you by the end of the call.

Jennifer: Okay, that would be amazing because I am a parent of a child receiving waiver services... and though we've been approved... our wonderful waiver service providers have not been able to staff... our case.

If they have been, it's very nominal. And so, my concern lies there, and more on the staffing-end, rather than you know... the pay increase.

That being said, the assumed wage is really low at $21.33.

Are you looking at different labor stats as they pertain to the medical and healthcare and educational work forces-- because that average seems to be closer to $30 an hour.

Stephen: So, the wage assumption itself is driven by a cross-industry... data source. So, I... didn't go into in detail in the presentation, but... I made a couple of references to the Bureau of Labor Statistics.

And, they group direct support professionals into broader categories that include folks working in other industries like... the... types of examples that you gave-- whether that's doing more home health type of work or... nursing facility related work, or in the behavioral health field.

It's still tied to the... kind of educational... and training requirements for DSPs. So, it's not tied to things like a certified nurse assistant... or a psychiatric... technician where there's additional educational and certification requirements.

But, it does certainly look at what staff that are working in different fields but have similar qualifications earn.

Jennifer: Okay, thank you for that.

Have you looked at the cost of living and the cost of housing? How do these factor into determining a livable wage, especially on Hawaii Island where commute is a larger factor to consider than other islands?

Stephen: So, there's not a specific tie to living wage. A lot of living wage calculators vary based upon family composition. So, the number of adults in the household that work or don't work, the number of kids, the age of the kids, and the like. So, it's really hard to come up with a figure that is a living wage-- because it's really more family... circumstance driven.

Instead, what we're looking at (as I mentioned a moment ago), is really the... Hawaii-specific data about what prevailing wages are for folks who are doing similar work.

And then, we applied... (I didn't mention a moment ago), but we then applied inflationary factors to account for ongoing wage growth and a further adjustment to account for an increase in the minimum wage (and the like).

Jennifer: Thank you! That answered a few of my other questions. So, my last one is...will you consider paying caregivers due to the shortage of staffing?

The Olmstead decision already determined that this model is way cheaper than the alternative-- which was institutions and all of... all we are asking is... for a pathway to honor the 1915C.

As a parent, I am not asking for additional resources-- just a pathway to do that.

Wendie: Sorry, I don't know that I understood the question.

So, we have a shortage of... DSPs (direct support workers)... and... our waiver service providers will be the first to tell you that.

But, the only people that can provide ... these services for CLSI and PAB is anybody but the guardians (the legal guardians or the natural parents within the home).

Other states are doing this-- such as Arizona (especially those that are... required to do CNA credentialing).

So, I just would like to see.. Hawaii be a leader in following suit to... really honoring the 1915C-- because we're not going in a good direction (especially with the cost of living here).

Wendie: So, you're talking about allowing... parents of minor... the minor participant to... be paid to provide services.

Jennifer: Correct. And, hi Wendy. I sent an email to you before. So, nice seeing you on video.

Wendie: Thank you! So, that is something that

I know Mary has mentioned she wanted to look into a little bit more.

Maybe something you know to consider in the future. So, it's not off the table.

It is open. We are (you know)... we have had some discussion about it at at the management level.

So... it is something we are looking into.

Jennifer: Amazing. Yeah... if there's anything I could do to provide more information... I'm an open book.

That's all of my questions. Thank you!

Stephen: But, I do.... Stacy have answers to Jessica's question on the turnover rate.

So, I have two data sources to share with you. The first is that provider survey that I made... reference to. We did ask for... turnover rates as part of that.

I don't have an aggregate figure. We did it by individual services. So… this is me kind of eyeballing the results. But, generally speaking, what was reported to us was in the 10 to 15% range.

The other thing that I have, and it's… actually older than I thought it was going to be. So, it's the National Core Indicator State of the Workforce Survey from 2022 (which is the last year for which I see Hawaii reported data).

And, back then the average turnover rate for participating Hawaii providers was 30%, and the median was 19%.

Jennifer: Thank you!

Wendie: So, we are currently doing the NCI right now with the providers-- so we don't have updated results (because I think we do it every three years.)

Jennifer: Okay. Yeah. Well, just as a parent, I would love to be more involved. So… I'm sorry I missed the previous… public comments… before, but whatever we can do to disseminate this to get more involvement… I'd be happy to facilitate that. One question for Wendy… What is the minimum age for DDD waiver services for minors? Is it nine?

For like…

Wendie: The minimum age for a person to receive services?

Jennifer: Yes… for intellectual disabilities.

Wendie: So, our… Waiver serves all ages.

There… might be some restriction on what type of services can be received at you know for certain ages… but… there isn't a minimum age.

Jennifer: Okay. Thank you for clarifying that.

Stacy: OK. Moving on…

Question in the Q&A… please… analyze… rate tiers… to reestablish higher tiers for expanded ARCH residents who medically require one-to-one care 24/7 (ordered by their primary care provider).

Any comments about that?

Wendie: So, I would say that that is more (and Stephen… I don't know if you want to speak to this)… but I would say that's more of a comment that should be provided in writing through the public comment period that starts on the 18th.

So, it… unless Stephen you have anything to say.

Stephen: I agree with you Wendie. The only thing I would add to that response is just a reminder for the commenter that there is a mechanism for folks in… ResHab environments (like E-ARCH) is to get additional… supports. It's the additional… staffing service (or am I misremembering the title Wendie)? I know we have… an additional service and… that's how additional residential supports.

Wendie: Additional residential supports.

Steohen: Additional residential supports. I missed a word in the middle there-- Additional residential support. So, that service is… available to provide staffing… over and above what's built into the standard ResHab rate.

Stacy: There are still a few providers (Waiver providers) that do not have in-house registered nurses. When is the Developmental Disability Division going to mandate waiver providers… to have a registered nurse?

Wendie: So, we don't… I don't believe that's something we are going to pursue. We do require providers who… serve participants… who have any type of nursing type task needs to have access to a nurse… but we don't dictate on them having to have a nurse on staff.

Stacy: Okay. This… next question came up about… slide 23 about the… minimum wage.

So, the last minimum… wage increase was in 2024 ($14 an hour). Stephen mentioned in 2026… the increase will be… $16 an hour. And the question is, will there be an increase to support the minimum wage increase for 2028 (which is scheduled for $18 per hour)?

Wendie: I would say that is definitely something we will be looking into. And of course, you know, as Stephen had mentioned throughout his… presentation, that we would have to ensure that we get the support of funding from the legislature and the governor. So… but that is something that we will be keeping in mind.

Stacy: Alright! Alright… Okay. How will… the rates be adjusted going forward… in regards to annual increase to take into account for inflation… and the increase in costs.

Wendie: So, the… and Stephen jump in at any time. The rates… we will not be increasing it annually.

The rate study was done to kind of take into account… inflation (in general), and the rate study is done every five years, right Stephen?

We… we've been doing it every five years. And, that would be to last for the next five years… (I guess), unless there's like increases in minimum wage and… whatnot.

Stacy: Barbara… had her hand up. Okay… next question.

Is there a plan to have a Developmental Disabilities Division foster home or a facility… exclusively housing highly behavioral participants?

Wendie: I... mean a... specific home just for highly-behavioral participants?

There is... discussion about a temporary situation-- not a forever home (like that).

But yes, there is... we are looking into different options.

Stacy: Okay... back to rates. Will the rates... for the direct-support professionals who are working consumer-directed also increase for higher-level SIS clients?

The services that are provided under consumer-directed are services that do not... I do not believe they have different tiers, for even under the agency side.

Stephen: That's correct! The tiers for agency services are... tied to those that are... shared supports (which generally aren't available through consumer direction).

I will say though that the consumer direction rates have a range, and that range has been adjusted in concert with the overall rate study. So, there's still flexibility... that individual participants have of setting their wage assumption for their... self-directed staff.

Stacy: Well, Stephen, when are... when will the next rate study be submitted?

Wendie: Well, the last one was 23 to 24. So, we should be planning for the next rate study in 2028 to 2029.

Stacy: OK.

Can happen between that time. Question about... the proposed... rate increases...

Will 100% of the proposed rate increase be implemented?

Wendie: Yes. What... is in the rate study and the rate models... that will be implemented--not like how it was before-- where we could only do a partial implementation. We are doing full implementation this time.

Participant: Great.

Stacy: Do the assumptions and requirements (for example the 60% of total payment regarding adult foster homes) also apply to licensed homes (such as the licensed ARCH houses)?

Stephen: The short answer is "no"-- because of the... more variety in terms of the service delivery models... where sometimes there's live-in staff, sometimes there's shift staff--and so the 60% requirement has only been proposed for the AFH service delivery model.

Stacy: Alright. A question about surveys... Stephen, you talked a little bit about surveys, and using those surveys as part of the insight process.

How are the surveys sent to providers?

Stephen: How are the surveys sent? So, there's contact information that DDD has in on file… that we used to communicate the… or to push the survey out. There was then… other strategies that we employed-- including asking our members of the provider advisory group… (which include representation from the provider association) to… advocate that their members or their colleagues participate in the survey.

But, the communication itself was prefaced by a message (I believe… if I'm recalling correctly from DDD), and then… my team followed up with the actual survey itself.

Stacy: Okay. And… how… will we know that an agency is following… the recommendation of at least 60% of total payment… to providers?

Wendie: Well… I mean, there's no… we won't know. But if you are a caregiver, you can see the rate that the agency is getting… paid for the service, and calculate how much the agency is paying you.

However, you know, there's also this… there's the pay amount. And, I don't know if the 60% Stephen includes benefits and other things… or if the 60% is actual pay to the caregiver.

Stephen: It's 60% of the total rate paid to the agency needs to be paid to the caregiver. I… don't believe there's any models where… the agency is making benefits available to their subcontractor. So, it's just the… payment itself to the subcontractor. And, I would just add to your… response when… you're right… there's not a specific reporting requirement to DDD (that we have proposed).

But, it's the same with any other service requirement. there's limitations on say staffing ratios, or there's minimum wages for direct support professionals.

None of that gets collected in real- time, but providers are expected to comply with all applicable requirements (including this new 60% requirement).

And, if there are… if non-compliance is found as part of say a post payment review… there would be the types of… sanctions and penalties (that are specified in provider agreements) that could be employed.

Stacy: A question about… (oh okay about the last program): "Is the Developmental Disabilities Division planning on any increases to… the LASR program in 2024. Providers agreed to comply with the rate increase… but were not able to increase the annual budget… for participants, which resulted in… a decrease in service hours to stay within the participant's budget.

Wendie: So, this is the LASR contract-- which is… 100% state funds. That is a separate conversation outside of this.

Stacy: OK.

And, a question about effective date, "When will the new rates take effect?"

Wendie: So, target implementation is January 1st, 2026, but that's always pending approval of our amendment from CMS.

Stacy: Ok. Could you please explain why adult foster home providers are not being paid for 365 days?

Stephen: So, that's an inaccurate statement. What the commenter... and a couple of commenters are suggesting... in the Q&A... or what they're referencing is the 344-day billing policy that's been established for... RESHAB services (both the group home type model as well as the AFHs).

That approach is meant to entirely benefit service providers. What we're doing is we're taking the annual expense (the assumed annual expense) and rather than dividing by 365, we're dividing by 344 (which means the daily rate is higher than it otherwise would be). Right? The denominator is lower, and it's... a little bit better than 6% higher than it otherwise would be.

And, what this allows DDD to do is... to fully pay a provider for a full-year worth of service over 344 billing days.

And, if we wanted to provide a really... kind of silly example to illustrate why this works, let's assume (and I'm going to make the math easy on me) that you earn $36,500 per year.

If you got paid $100 per day for 365 days, that's the same as getting paid $36,500 on January 1st.

You're making the same amount of money regardless of whether we're paying that to you on day one, or paying you $100 a day every single day for 365 days.

The reason that we propose and DDD (since 2016) has been paying... based upon this 344-day billing year is because... people are occasionally absent.

But, when they're absent, a provider's cost doesn't necessarily change, right?

Particularly, if we're talking about say... a group home-- they still have to have the same number of staff there... regardless of whether or not one resident has spent the weekend away with their natural family.

By paying an inflated rate (by dividing by 344 rather than 365), providers get paid for a full-year worth of service... as long as that participant is there for 344 days. And, another way to look at it... is it provides insurance for up to 21 absences per year.

And, it's... at the end of the day... it's mathematically impossible for a provider to be worse off... under this policy than if we had a 365-day rate.

If a individual is there for 365 days, the reimbursement is exactly the same.

If they're there for 364 days, the provider earns more money with 344 (because they don't lose any revenue).

If they're there for 363 days, you lose two days of revenue under a 365 policy.

You lose $0 of revenue under a 344-day policy. So, this is ensuring that providers get fully paid as long as the individual is there for 344 days. If we went the other route and had a 365-day billing policy, once the individual is absent for one day, providers start losing money.

[Inaudible]

Stacy: Okay. Salary adjustment needs to be done more frequently than every 5 years. How can that be changed?

Stephen: If I can just speak to that briefly, Wendie.

Wendie: Sure!

Stephen: So, I want to differentiate between conducting a comprehensive rate study, versus potentially making adjustments to reimbursement rates.

It takes a lot of time, and it costs a not insignificant amount of money from the state to conduct the comprehensive rate study.

So, DDD has been doing that on an every four to five-year cycle consistent with what the federal requirements are.

But, that's not to say that rates cannot be adjusted in between those rate studies. And, in fact, that's what's happened in recent years.

There were a variety of adjustments made since the last rate study-- including the update that we've made reference to for the minimum wage increase back in January of 2024.

But, it's also true that the division doesn't have the money to do that on their own.

And so, any consideration of adjusting rates in between the rate studies themselves… would have to go through the state's budgeting process and receive approval.

So, it's not that they can't be done. And in fact, it in recent years, the division has granted a number of rate increases between the 2020 rate study and the 2025 rate study.

But, it's always going to be dependent upon the ability to get that additional appropriated funding (in order to afford it).

Participant: Thank you.

Stacy: Anything, Wendy?

Wendie: No. I agree with… like what Stephen said (you know)-- our last amendment we did was on… effective November 1st, 2023-- which did implement increase rates that were not based… that were not… did not have a separate rate study for that.

We were able to do that be um due to the increase in minimum wage… and the budget approval.

Stacy: Okay.

Switching a little bit outside… but related… "What is the monitoring like for providers?"

Wendie: Sorry, can you repeat that?

Stacy: Mmm… hmm. The question is about monitoring of providers. What is the monitoring like for providers?

Wendie: I don't know… I fully understand the question. Providers get monitored-- program monitoring and fiscal audit annually. But, I'm not sure I understand how else to answer that question. [Laughing]

Stacy: Alright…

It was mentioned there were documents available on the topics being discussed in the webinar account.

Yes. So… like we mentioned earlier in the presentation, this… slide deck as well as the recording… will be posted on our DDD website.

We will work as quickly as we can to do that.

But, we will let you know when it is available. You can check… the DDD website under… the option for news, and you should see a highlight there when it is posted.

Wendie: And, we will be posting the rate models up… by sometime tomorrow under the news section.

Stacy: Alright. A question about Big Island rates. What… would the Big Island rates be? And, will… consumer direct providers… now be able to get medical insurance as a comprehensive benefit?

Can consumer direct providers not get paid mileage when providing… CLS?

Wendie: So, there's… multiple questions in there. Consumer-directed when providing CLS the… transportation is included in the service. So, it's there is not a separate payment for mileage.

And, what was the other question?

Stacy: Right. So, what are the big island rates? And then, specifically for consumer direct providers in regards to their benefits… insurance comprehensive benefit plan and mileage reimbursement.

So, the big island rates will now be… other island rates which will be… posted in the rate models once… on our website from tomorrow. So, you can check those out there.

Oahu rates will also be posted (of course).

Whether or not consumer directive will include medical… no that is not something that is being… done right now.

Stacy: Alright. We have several… other questions. So, we also have… hand raised… Byron and… Liza.

I'm going to go ahead and un-mute you. Are you wanting to share your question?

Go ahead.

[No Audio]

Byron… Liza?

Stacy: No?

Okay. Okay. So, just wanted to… wrap up… because we have just a few minutes left.

As a reminder… please… take time to submit your public comment.

Things that we went over today (both in the Q&A and in the presentation)-- you're welcome to submit your comments in these ways.

I know… there are many… different types of attendees today. Whether you're a provider… parent or guardian… participant or your… DDD staff… everyone is welcome… to submit… public comments. So, we appreciate you taking the time… to do that.

And, any… closing thoughts… final comments from Stephen… Wendie before we… end today's webinar?

Wendie: I just want to thank everyone for joining in and listening and asking your questions and we look forward to… any of the comments that you guys submit but again it has to be in writing through the… either the CRB email or by mail.

So, thank you.

Stacy: OK.

Alright. That is it for today. Thank you very much… for being here!

We appreciate all of your time, and have a great rest of your day! Thank you so much!