

# WAIVER STANDARDS TRAINING

June 9, 2026

Effective July 1, 2026



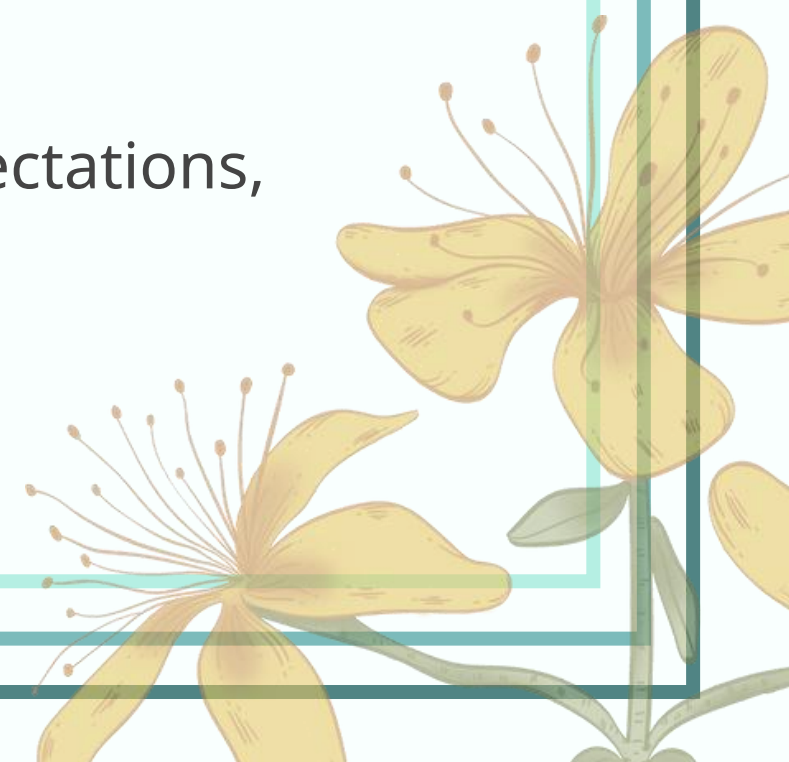
# What's Driving the Changes to the HCBS 1915c Waiver Provider Standards

- **CMS Driven Changes**

- New CMS Waiver Application – Updated template required states to strengthen quality oversight, service delivery assurances, and telehealth expectations
- Alignment with Federal Regulations – Standards were revised to ensure consistency with current federal rules and CMS guidance
- Alignment with Federal Employment Services Definition – Employment-related standards now reflect federal definition supporting competitive integrated employment

- **State-Driven Changes**

- Enhanced Service Quality – Updates strengthen performance expectations, monitoring, and accountability for providers
- Expanded Access to Services – updates improve access to services
- Stakeholder feedback informed key changes



# A G E N D A

- ❖ Waiver Renewal and Waiver Standards Update
- ❖ Navigating Changes in the Waiver Standards
- ❖ Section 1: General Requirements & Information – Waiver Overview
- ❖ Section 2: Quality Management Overview and Requirements
- ❖ Section 3: Medicaid I/DD Waiver Provider General Requirements and Standards
- ❖ Section 4: Service-Specific Performance Standards

# Waiver Renewal and Waiver Standards Update

- The Waiver application for the 2026 Waiver was submitted to CMS on March 30, 2026.
- DDD and MQD had a 15-day call with CMS on April 13, 2026.
- CMS sent an Informal Request for Additional Information (IRAI), which DDD and MQD responded to on May 13, 2026.
- The Waiver Renewal and the Waiver Standards are targeted to go into effect July 1, 2026, pending CMS approval of the Waiver.

# Navigating Changes in the Waiver Standards

- See Summary of Changes table on pages 10-17.
- All changes in the Waiver Standards are highlighted in yellow throughout.
- The Waiver Standards is effective July 1, 2026, pending CMS approval of the Waiver Renewal.



TABLE: Summary of Changes in Waiver Standards effective July 1, 2026

Page	Section	Topic	Summary of Change
11	Introduction	Community Integration	Updated this section to change from HCBS Final Rule to HCBS Settings Rule and include full compliance date
18	1.2.B	Participant, Family and Guardian Responsibilities	Added clarifications to some of the participant responsibilities
20	1.3.A	MAG-Excepted Income and Assets	New section added
30	1.3.C	Financial Eligibility Requirements for Children	Clarified Medicaid eligibility requirements
32	1.4.B	Medical Annual Renewal	Clarified process for annual renewal of Medicaid
33	1.5.A	ISP Development, Updates, and Revisions	Added Procedures as part of the ISP development process.  Added timeline for the ISP to be entered into DSP/E and available through the Provider Portal.  Clarified the requirement of the participant, parent and/or legal guardian signatures on the Consent for Services.
34	1.5.B	Individual Support Budget	Clarified that the participant should always be present at their ISP meeting unless they choose not to participate.  Updated this section with the use of the SIS-A 2 <sup>nd</sup> Edition and changes to the description of SIS Levels.
35	1.5.B.1	Individual Support Budget	Added the new service, Personal Care Assistance, as a base service subject to the Individual Support Budget
35	1.5.B.1	Individual Support Budget	Updated Individual Support Budget request
36	1.5.D	Service Authorization	Clarified that parent or guardian signature is required on the Consent for Services
38	1.6	Participant Rights and Protections	Added the right of participants to request a different CSM

Waiver Standards  
Effective July 1, 2026  
10

# Application and Start of Waiver Services

Section 1.3 pg. 30-32

## *MAGI-Excepted Income and Assets*

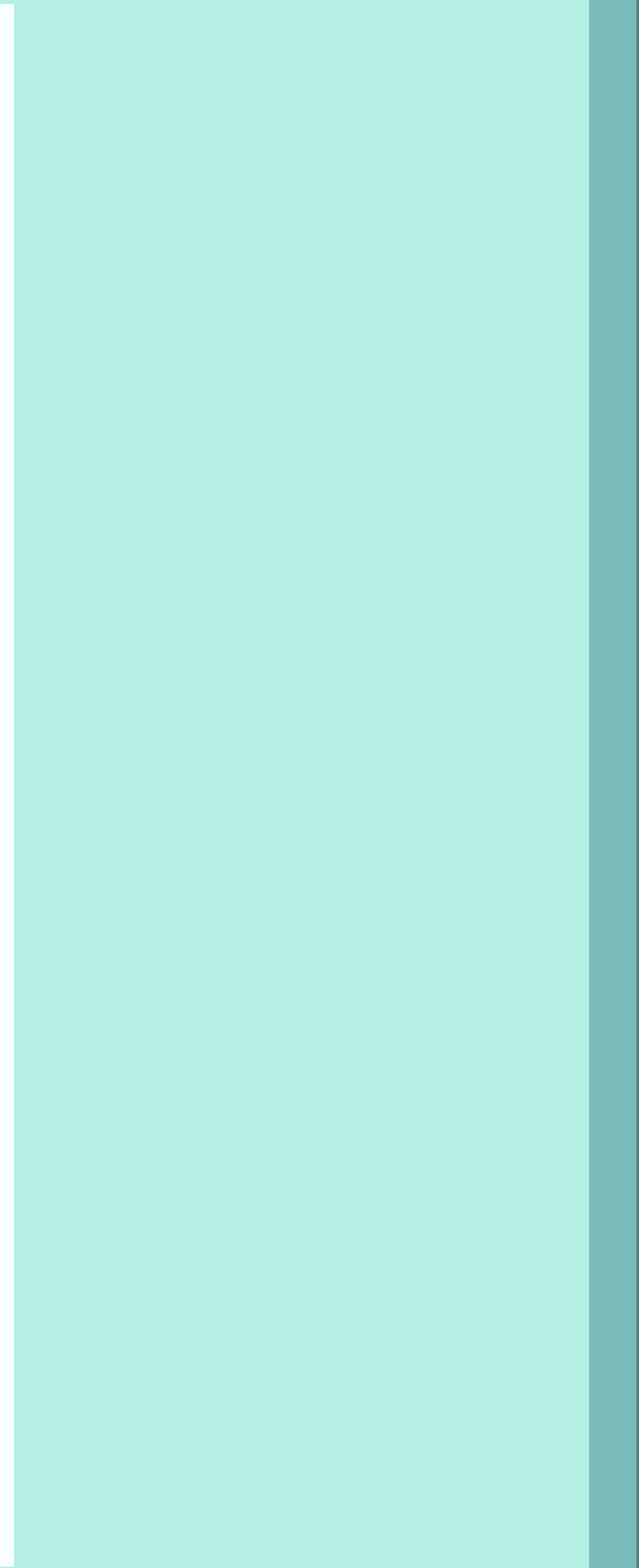
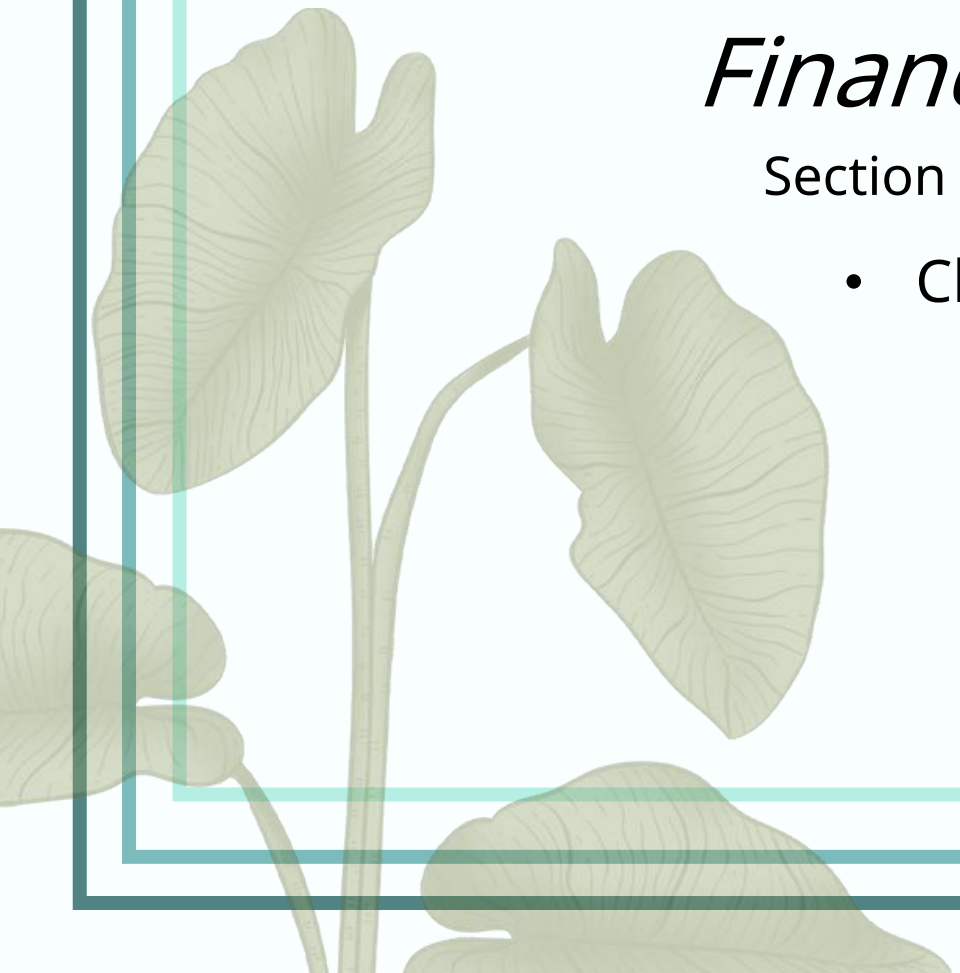
Section 1.3-A pg. 30

- Income and Asset Determinants

## *Financial Eligibility Requirements for Children*

Section 1.3-C pg. 30-31

- Children under age 19 Medicaid eligibility



# Re-Evaluation of Eligibility for Continued Waiver Services

Section 1.4 pg. 32

## *Medicaid Annual Renewal*

Section 1.4-B pg. 32

- Annual Renewal
  - Electronic vs Paper



# Roles and Responsibilities

Section 1.2 pg. 28-29

## *Participant, Family, and Guardian Responsibilities*

Section 1.2-E pg. 28-29

### Added clarifications to some of the participant responsibilities:

#### **Responsibility:**

Participants and/or their legal decision makers shall please notify the Case Manager immediately of any changes to Medicaid Eligibility.



#### **Why?**

Because our participants need to be eligible for Medicaid to have the 1915(c) HCBS Waiver for Individuals with I/DD, which funds their provider services.

#### **The participant/guardian should notify:**

1. Their local Medicaid eligibility office, who can help them address the eligibility issue;
2. Any Waiver provider they receive services from, and CD services (Acumen), if applicable;
3. Their Case Manager (CM) because the CM can help contact providers, refer them to resources to help with Medicaid issues, and help plan for service changes.

# Individualized Service Plan (ISP)

Section 1.5 pg. 32-37

## *ISP Development Updates, and Revisions*

Section 1.5-A pg. 32-34

## Your Voice, Your Vision, Your Plan!



Clarified that the participant should **ALWAYS** be present at their ISP meeting (unless *they* choose not to participate).



The participant gets to choose who they want and don't want at their ISP meeting.



**Added Providers as part of the ISP development process:**

- Providers are a crucial part of ISP development, and unless a participant chooses to not have them attend, we want them included in the person-centered planning process!







# Individualized Service Plan (ISP)

Section 1.5 pg. 32-37

## *Individual Supports Budgets*

Section 1.5-B pg. 34-36



Updated this section with the use of the SIS-A 2<sup>nd</sup> Edition and changes to the description of Supports Intensity Scale (SIS) Assessment Support Levels:

- DDD started using the SIS-A in 2017 and the SIS-A 2<sup>nd</sup> Edition on 7/1/2025; the 2<sup>nd</sup> edition is an updated version of the SIS-A. This assessment is for DDD participants ages 18 and older who are in Waiver.
- Like the original SIS-A, the SIS-A 2<sup>nd</sup> Edition determines what a participant's Support level will be (1-7); this will determine the participant's Individual Support Budget and is also used to help guide service planning during the ISP meeting.
- DDD redescribed the SIS levels, using more concise language to describe the type of support someone may require who falls under that level.



# Individualized Service Plan (ISP)

Section 1.5 pg. 32-37

## *Individual Supports Budgets*

Section 1.5-B pg. 34-36

Added the new service, Personal Care Assistance (PCA), as a base service subject to the Individual Supports Budget (ISB):

- This means PCA services, if you chose this service, will be included in your Individual Support Budget.

Updated Individual Supports Budget ranges:

- The ranges within the ISBs were revised to correspond with the increased service rates to ensure participants can still access their services.

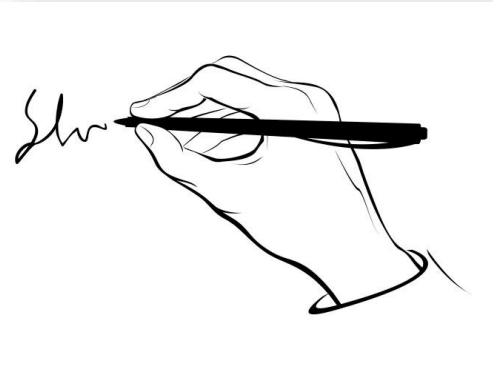


# Individualized Service Plan (ISP)

Section 1.5 pg. 32-37

## *Service Authorization*

Section 1.5-D pg. 37

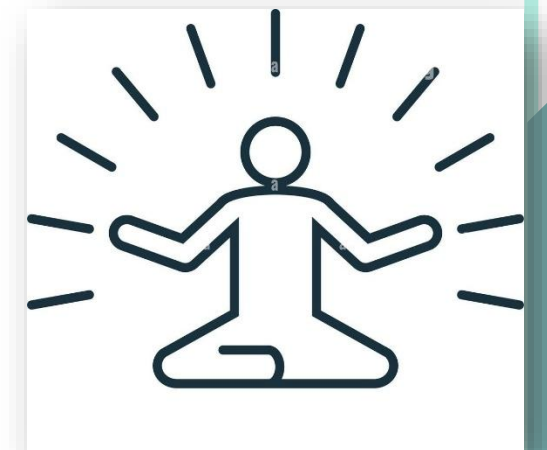


Clarified that the participant, parent or guardian signature is required on the Consent for Services.

- The Participant will sign the Consent for Services when they are their own guardian.
- If the Participant is not their own guardian, they can sign and the Consent must also be signed by the legal decision maker.

Added the right of participants to request a different CM.

- The participant may request a different CM. This request should be what the participant wants.
- Your CM will try to help mediate whatever the concern is.
- The unit wants to make sure that a change in CM is going to help resolve the concern!



# Consumer Direction

Section 1.8 pg. 53-56

- **Clarified expectations of the CD employers and process of remediation and termination:**
  - If the CD employer is struggling with the responsibilities of self-direction, we will try to support them through remediation processes.
  - Failure to adhere to the guidelines and legal standards after support, training and remediation may result in termination of the CD program, with a choice of waiver providers as an alternate option.
  - The CD employer **MUST** ensure that services and funds are available to support the participant throughout their plan year, and as identified in the ISP.
- **Clarified the Fiscal Management System assistance to ensure participants support throughout the ISP plan year.**
  - All CD Employers must train their employees on the ISP goals and submit the CD Annual Training Verification form annually!



Choice, Control, Community

# Participant Safeguards

Section 1.7 pg. 38-53

## *Nursing Assessment and Delegation*

Section 1.7-D pg. 45-52

**New services, PCA and RCS, are added to the list of services that includes nursing supports.**

- PCA or Personal Care Assistance
- RCS or Residential Care Supports
- **Both of these services are added to the list of those services that T & C RN is built into the service.**
  - This means that nursing is a part of the service for the purpose of developing, overseeing, training, and documenting plans for delegation of nursing tasks performed during the delivery of service.

### **Clarified requirements:**

- Providers of the services that includes nursing supports, should have access to a registered nurse, either on staff or by contract.
- Nursing assessments are to be on the DDD Nurse Assessment form and nurse delegation plans to be on the DDD Nurse Delegation Plan form.
  - DDD updated the **DDD Nurse Assessment** form and created a standardized **DDD RN Delegation Plan** form. These will be effective in use starting 7/1/2026. (The forms and instructions will be sent to providers prior to this date).

# Participant Safeguards

Section 1.7 pg. 38-53

## *Nursing Assessment and Delegation*

Section 1.7-D pg. 45-52

### DDD RN Assessment

DDD PROVIDER NURSING ASSESSMENT			
<b>1. Background Information</b>			
Date:		RN Provider Agency:	
Participant Name:		Provider RN conducting the nurse assessment:	
Date of Birth:		CMB Unit & CM:	
Health Plan Name:		Health Plan Service Coordinator:	
Guardian (if applicable):		Residential Setting:	
Medical History:			
Medical Stability: <i>(include all risk factors, precautions, hospitalizations, and AERs in the past year)</i>			
Diet/Nutrition:			
Durable Medical Equipment/Medical Supplies:			
Medications/Allergies (please include medication name, indication, dosage and route, and ordering physician):			

### DDD RN Delegation Form

DDD RN Delegation Plan					
To accompany RN Assessment					
<b>Demographic Information:</b>					
Participant: _____		RN Delegating Tasks: _____			
(Name)		(Name)			
Setting: _____		Physician's Orders Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No			
(for delegating tasks)					
ISP Plan Year: _____					
<b>All Current DDD Waiver Services:</b> (Please list)					
Service	Agency Provider	RN Delegated Task	Service	Agency Provider	RN Delegated Task
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Rationale:</b> (Please describe the reason and intent of the RN delegation.)					

# Participant Safeguards

Section 1.7 pg. 38-53

## *Nursing Assessment and Delegation*

Section 1.7-D pg. 45-52

- **Added requirements:**
  - All identified substitute caregivers must meet state delegation requirements when nursing tasks are delegated during ResHab services.
  - T&C – RN is only for services where nursing supports is not included in the service.
  - The Nursing Assessment, Nurse Delegation Plan, and training and skills verification are to be submitted to the CM upon completion.
  - The Provider RN will conduct follow-up upon discharge if a participant is hospitalized, including a face-to-face visit when requested by CM.
    - The timeframe in which the Provider RN will need to conduct a face-to-face visit with the participant will be determined by the CM, who will consult with their unit nurse.
- **Changed the timeline for completion of the Nursing Assessment and the Nurse Delegation Plan:**
  - New participant, new services = RN Assessment is due 15 days from date of the ISP meeting and prior to the start of services.
  - For ongoing services = RN Assessment is due prior to the scheduled ISP meeting.
  - Delegation Plan = Within 15 days of the completion of the RN assessment and prior to the start of services.

# Participant Safeguards

Section 1.7 pg. 38-53

## *Nursing Assessment and Delegation*

Section 1.7-D pg. 45-52

Clarified Requirements of certain nurse delegation tasks and nursing tasks:

- **Non-prepared intra-muscular injections** = RN only, cannot be delegated.
- **Anticonvulsant rescue medications** = Replaced only certain anticonvulsant rescue medications that were named in the previous standards; now includes all.
- **Sterile dressing change** = RN only, cannot be delegated.
- **Foley catheter irrigation, and suprapubic catheter change** = RN only, cannot be delegated.

# Participant Safeguards

Section 1.7 pg. 38-53

## *Medication Management*

Section 1.7-E pg. 52-53

It is currently stated in the Waiver Standards that if a participant is going to engage in medication self-administration, this must be assessed and documented by a health care practitioner with prescriptive authority on an annual basis.

Added requirement includes documentation in the ISP that a participant is independent in medication self-administration, including the expiration/renewal date.

# Role of Providers in Implementing Quality Management (QM) Practices

Section 2.3 pg. 60-67



- Removed language for Providers to begin development of a QM Plan
- Expectation that all Providers have a QM Plan
- Provider QM Plan will be part of the Provider Monitoring review.



# Participation as a Medicaid I/DD Waiver Provider

Section 3.1 pg. 69-73

## *Applying For or Amending Participation as a Medicaid I/DD Waiver Provider*

Section 3.1-C pg. 70-73

- Providers needing assistance with HOKU may email [HCSBInquiries@dhs.Hawaii.gov](mailto:HCSBInquiries@dhs.Hawaii.gov), or call 833-909-3630, or refer to the HOKU website.
- Clarified when insurance is required for professional liability and automobile.
  - Professional liability is required when services requiring licensure through the Hawaii Department of Commerce and Consumer Affairs are provided.
  - Automobile insurance is required if any vehicle is used to transport a participant during a Waiver service.



# General Requirements for Medicaid I/DD Waiver Providers

Section 3.2 pg. 73-76

## *Electronic Visit Verification (EVV)*

Section 3.2-E pg. 74-75

- Added new service, Personal Care Assistance (PCA), to list of services subject to EVV.
- Clarified that ResHab, Residential Care Supports, and Respite Daily are not subject to EVV because those services are provided in a licensed/certified setting.

## *Transition, Coordination, and Continuity of Care*

Section 3.2-F pg. 75-76

- If a provider is terminating a Waiver service for a participant, written notice must be provided to the participant and the CM.
- If a provider is terminating a Waiver service from their array of services, written notice must be provided to the participant(s), CM(s), and CRB.

# Conflict of Interest

Section 3.3 pg. 77-79

To ensure participants are not exploited and to safeguard against waste, fraud, and/or abuse of the participant and the services they receive, DDD has an obligation to prevent situations that could create a conflict of interest.

Service delivery must be conflict free to the maximum extent practicable, while preserving the participant's right to free choice of Providers and person-centered decision-making.

A Provider agency shall not furnish Waiver services to a participant where a conflict of interest exists, unless such conflict is fully disclosed and appropriately mitigated, if the agency, or any owner, officer, director, member, or partner of the agency has direct personal, financial, or legal relationship to the participant.

Providers shall disclose any conflict of interest to CRB by August 1, 2026.

This does not apply to the Consumer-Directed option.



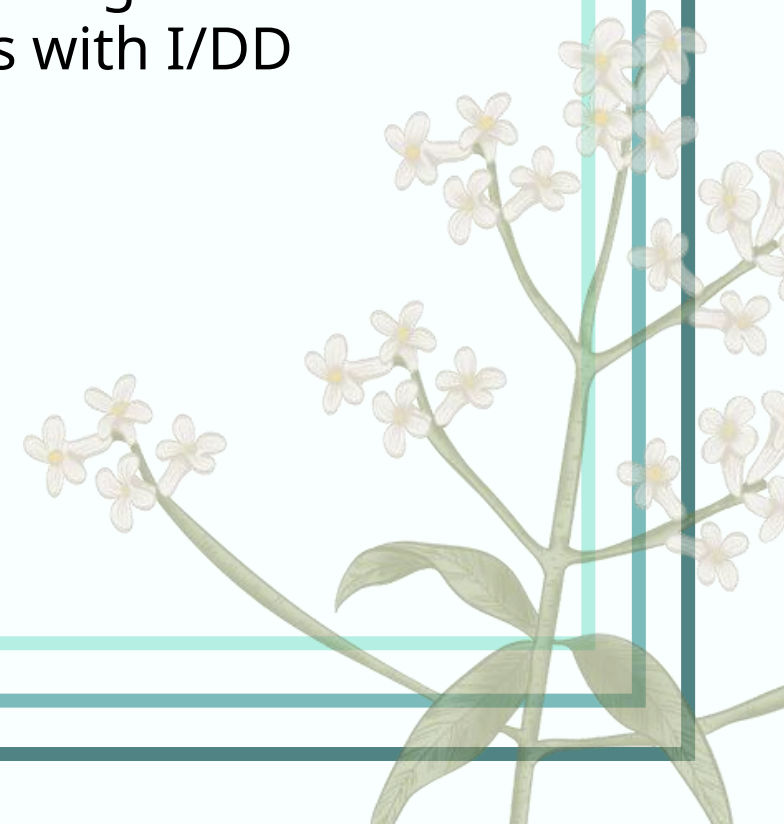
# Direct Support Professional Certification

Section 3.6 pg. 93-95

*New Program to Increase Quality of Service and Align Workforce for Retention Opportunities*



- ❖ Added recognition of Level 1 Certification of Direct Support Professionals through the National Alliance of Direct Support Professionals (NADSP)
- ❖ Certification is required for the DSP Certified Supplemental Payment
- ❖ Achievement of certification has become an industry standard in attesting to the delivery of competency-based best practices in supporting individuals with I/DD
- ❖ DSPs are able to achieve certification through the agencies



*To Achieve Certification,  
DSPs must complete accredited curriculum and  
provide attestation as proof of competency in 11 areas*

- **DDD Subsidized Training Program - Workforce Development Training Program**

- Provided at no cost to agencies
- Open enrollment every three months for a cohort of 120 learners
- Accredited curricula, enrollment in NADSP e-Badge Academy, Infrastructure, Facilitation, nominal funding to offset training expenses, and continuing ed for certified professionals

- **Provider Agency Training Program**

- May be cost prohibitive and restrictive
- Accredited curricula is separate and a part of the certification requiring additional vendor licensing
- There is a large administrative burden to integrate and operate the required functions

# Staff and Licensed/Certified Caregiver Qualification Requirements

Section 3.5 pg. 82-93

## *Additional Qualifications for Service Supervisors*

Section 3.5-D pg. 87-90

- ❖ Added new requirement of an Attestation Form to document minimum qualifications for a Service Supervisor.
- ❖ The Attestation Form is required if a Service Supervisor's qualifications are outside of a bachelor's degree from an accredited college or university in social sciences or education

STATE OF HAWAII  
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION  
Community Resource Branch

**ATTESTATION FORM**  
(Use for verifying Service Supervisor qualifications)

The agency must retain the original signed form in the employee's personnel file for the duration of their employment. Complete and submit this attestation form and upload it to the Provider Portal.

Provider Agency Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

I attest that the employee listed above possesses one of the minimum requirements checked below for the Service Supervisor position, to provide services to participants in the Home and Community Based Waiver for Individuals with Intellectual and Developmental Disabilities (UDD Waiver).

Bachelor's degree from an accredited college or university in a field other than social sciences or education with one (1) year verifiable experience working directly with individuals with disabilities or the elderly.

Registered Nurse license in the State of Hawaii.

High school diploma or equivalent (GED) and a minimum of two (2) years of experience providing direct assistance to individuals with intellectual and/or developmental disabilities and has met all requirements listed below:

- Has been employed by the agency for a minimum of six (6) months;
- Will be under the supervision/oversight of a qualified staff who will co-sign for the first six (6) months; and
- Possesses people skills, advocacy skills, ability to build relationships and verbal and written communication skills.

Qualifications from an accredited foreign college or university with one of the requirements listed below:

- Document verification that the degree is equivalent or higher than a bachelor's degree in the United States; or
- Document verification of acceptance of admission to a graduate program at the University of Hawaii, Hawaii Pacific University, or Chaminade College.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.

UDD Waiver: Attestation for Service Supervisor Qualifications July 2020

# Programmatic Requirements

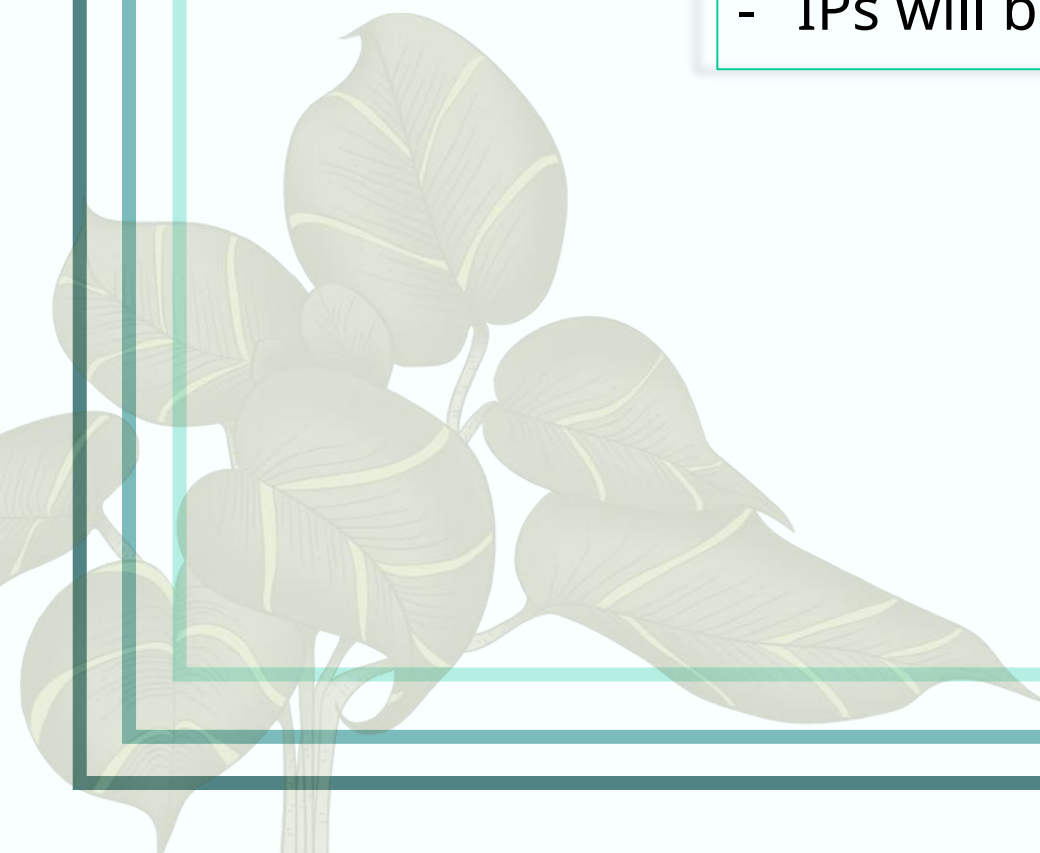
Section 3.7 pg. 95-103

## *Individual Plan Development and Updates*

Section 3.7-A pg. 95-97

Updated this section to align with DDD's new P&P 18.09 IP and Quarterly Reports

- Individual Plans (IP) must be completed on the designated template through the Provider Portal
- IPs will be reviewed and approved by the case manager



# Programmatic Requirements

Section 3.7 pg. 95-103

## *Quarterly Reports to Case Manager (or More Frequently)*

Section 3.7-B pg. 97-98

Updated this section to align with DDD's new P&P 18.09 IP and Quarterly Reports

- Quarterly Reports must be completed on the designated template through the Provider Portal
- Quarterly Reports will be reviewed and approved by the case manager
- Clarified that Quarterly Reports align with the participant's plan year

# Monitoring Provider Agencies

Section 3.11 pg. 120-126

## *DDD Responsibilities*

Section 3.11-A pg. 120-125

Updated this section to reflect the new provider monitoring process

- ❖ Monitoring documents shall be submitted through the Provider Portal
- ❖ Monitoring shall be conducted at least once every 3 (three) years
  - If a provider receives a CAP, they will be reviewed the following year

Program Monitoring:	Validation:
<ul style="list-style-type: none"> <li>▪ Adult Day Health (ADH) and Residential Habilitation (ResHab) providers shall complete and submit an Attestation Form annually, to confirm no changes to the Settings Rule Evidence Templates submitted</li> </ul>	<ul style="list-style-type: none"> <li>▪ Added additional documents that may be required for review: TB Clearance, First Aid &amp; CPR, Fieldprint, State e-Crim, APS/CAN Clearance, <b>Attestation Form for LEIE, Attestation Form for Med-QUEST Excluded Individuals, Highschool Attestation Form, Bachelor’s degree, Attestation Form for Service Supervisor, Licenses and Certifications (RN, BCBA, OT, RBT etc.), Orientation and Annual Training</b></li> </ul>
<ul style="list-style-type: none"> <li>▪ Review of Individual Plans (IPs) will include a 24-month period</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Added additional documents that may be required for review: Emergency Preparedness (EPP) Plan Attestation Form, Quality Management Plan and Attestation Form, Attestation Form for settings, Interest Inventory, Discovery Profiles, Documentation of Discovery Action Meeting, Customized Employment Plan, and Job Coaching Fade Plan</li> </ul>	



# Billing and Claims Processing

Section 3.8 pg. 103-113

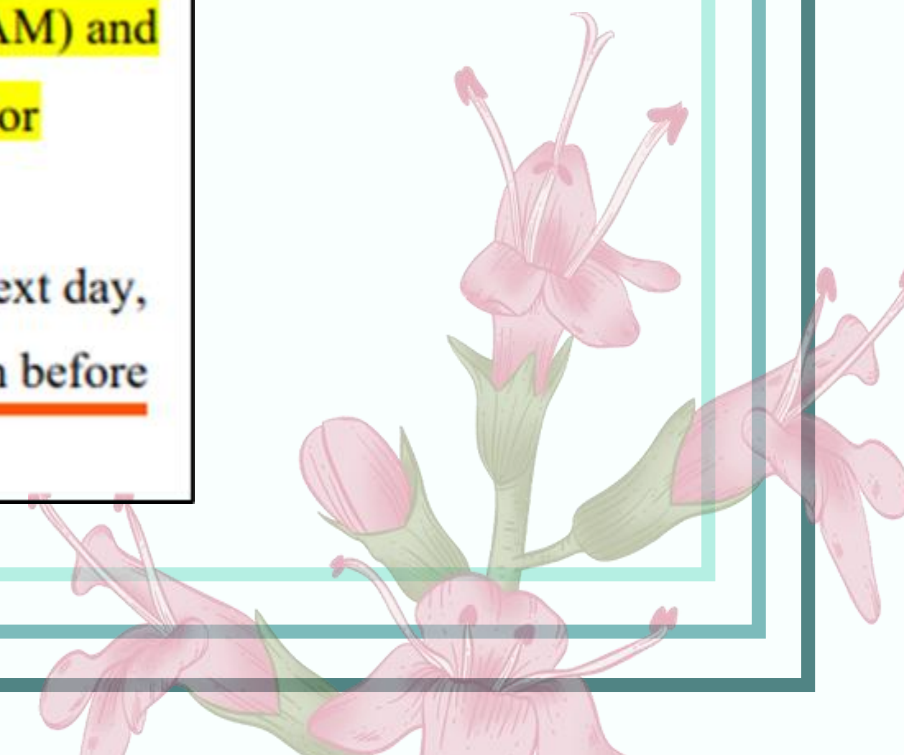
## *Billing for Claims*

Section 3.8-A pg. 103-108

- Added clarification on rounding for 1 hour units and \$1 units.
  - One 1-hour unit is 31 or more minutes
  - One \$1 unit is \$0.51 or more.
- Clarified EVV billing instructions for overnight services.
  - Clock-out before midnight
  - Clock-in after midnight

d. For overnight services, the DSW may need to clock-out before midnight (12:00 AM) and clock back in right after midnight (12:00 AM), depending on the EVV vendor. For example:

If a participant receives services subject to EVV from 8:00 PM to 5:00 AM the next day, the DSW must clock out after 11:57 PM and prior to 12:00 AM and clock back in before 12:03 AM in order to be able to bill a correct number of units.



# Billing and Claims Processing

Section 3.8 pg. 103-113

## ***Billing Accuracy***

Section 3.8-B pg. 108

- Added a new section focusing on the accuracy of billing for claims to minimize billing errors.

## ***Timely Submission of Claims***

Section 3.8-D pg. 110-111

- Added instructions to request a waiver of the filing deadline for claims.

# Financial Accountability – Post-Payment Reviews

Section 3.10 pg. 114-120

## ***Documentation Requirement for All Billable Claims***

Section 3.10-A pg. 114-115

- Clarified the ISP and Consent for Services requirements.
- Updated service record requirements to provide clearer, more detailed guidance.



# Financial Accountability – Post-Payment Reviews

Section 3.10 pg. 114-120

## *Fiscal Audit*

Section 3.10-B pg. 115-119

- Updated the fiscal audit process to provide clearer, more detailed guidance in several of the steps.
- Added a second Informal Appeal process to give providers another opportunity to resolve an audit finding.



# Telehealth

Section 4.1 pg. 129-131

Updated this section to address new CMS requirements and assurances. Providers must develop and update a Telehealth policy and procedure (P&P ) to address the following new CMS requirements for continued delivery of services by telehealth:

- **Privacy of the Individual** – respects privacy of the individual, especially in instances of toileting, dressing, etc.;
- **Support Community Integration** – allows individuals to engage with their community without requiring transportation or in-person staff presence for every interaction;
- **In-Person Support** – shall be used in conjunction with telehealth, if needed;
- **Training and Technical Support** – providers shall provide training and technical assistance to individuals and caregivers if needed; and
- **Health and Safety** – telehealth service may only be used when it is safe and appropriate for the individual and documented in the ISP

# Supplemental Payments

Section 4.2 pg. 132-139

## ***Expanding AFH Capacity on the Neighbor Islands***

Section 4.2.1 pg. 132-134

The purpose of the supplemental payment is to incentivize ResHab providers to support/assist new caregivers to become a certified adult foster home (AFH) and match participants with caregivers who can meet their long-term needs.

ResHab providers may be eligible for the supplemental payment when they successfully place participant(s) into a newly certified AFH on a neighbor island:

- Newly certified AFHs are homes that have not been certified as an AFH within the past 6 months
- Successful placement means the participant has remained in the AFH for a minimum of 120 days

Two payments available:

- \$5,000 for placement of first participant
- \$2,500 for placement of second participant



# Supplemental Payments

Section 4.2 pg. 132-139

## ***Competitive Integrated Employment (CIE)***

Section 4.2.2 pg. 134-136

The purpose of the supplemental payment is to incentivize Employment providers to support participants to obtain and maintain competitive integrated employment (CIE) in a job that is a good fit.

Providers of Discovery and Career Planning (DCP) and/or Individual Employment Supports (IES) may be eligible for the supplemental payment when they successfully support a participant to obtain new CIE:

- CIE is employment at a workplace in the community where the participant receives at least minimum wage and where majority of individuals do not have disabilities
- Successfully support means the participant is employed in a job that aligns with their employment goals, interests, and abilities for a minimum of 90 days

One payment of \$5,000 is available when a participant is scheduled to work a minimum of 10 hours per week for at least 10 weeks and has worked at least 100 hours in the 90 days of employment.



# Supplemental Payments

Section 4.2 pg. 132-139

## *Certified Direct Support Professionals*

Section 4.2.3 pg. 137-139

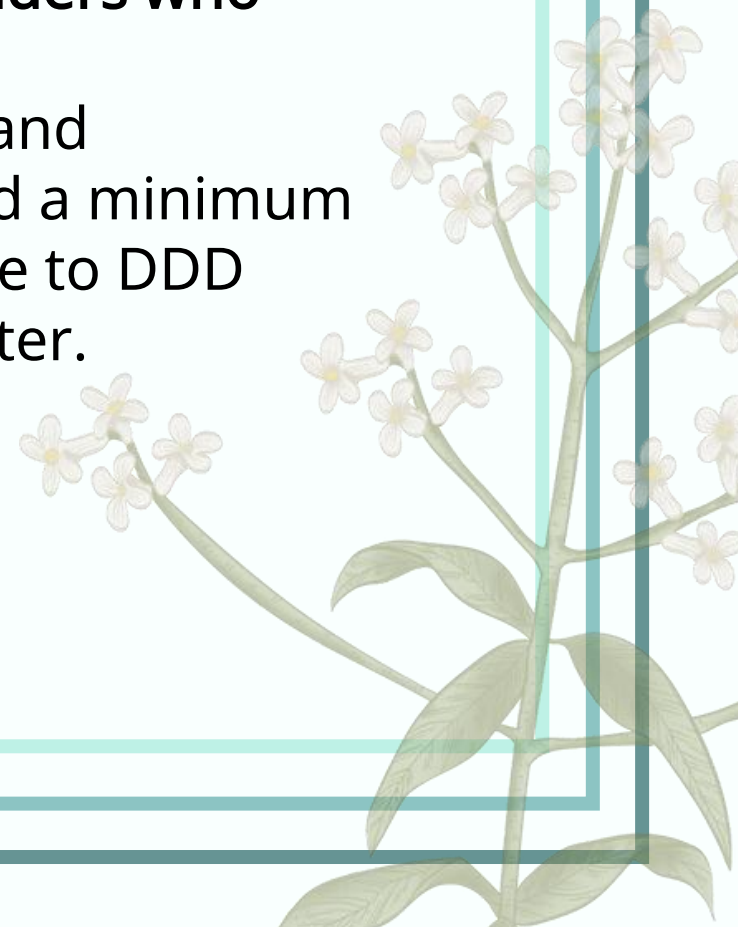
The purpose of the supplemental payment is to incentivize providers to encourage and allow their direct support professional (DSP) workforce to obtain National Association for DSP (NADSP) Level 1 Certification and directly impact DSPs employee compensation. This may set a career pathway towards certification, provide higher compensation for certified DSPs, and increase staff retention.

### **Eligible Providers of one or more of the following services:**

- Adult Day Health (ADH)
- Additional Residential Supports (ARS)
- Community Learning Service – Group
- Community Learning Service – Individual
- Community Navigator
- Discovery and Career Planning
- Individual Employment Supports
- Personal Assistance/Habilitation

### **Quarterly payments of \$1,250 are available for each certified DSP for providers who have:**

- Volunteered to participate; and
- A certified DSP that provided a minimum of 260 hours of direct service to DDD participants within the quarter.



# Community Navigator

Section 4.8 pg. 180-186

**Service Description:** To elevate service quality for personalized, meaningful outcomes for participants, added the Community Life Engagement Guideposts, developed by the Institute for Community Inclusion at University of Massachusetts, Boston (ICI):

- Individualize supports for each participant.
- Use human and social capital to decrease dependence on paid support.
- Ensure that supports are outcome-oriented and regularly monitored.

**Staff Qualification Requirements:** Clarified that all trainings and certifications will be conducted and issued by DOH-DDD. Building upon the foundation of the first CN training, creating a more accessible training with enhanced curriculum.

**Documentation Standards:** Added the requirement that the Community Navigator plan shall be completed and shared with the participant, circle of support, and CM prior to the end of the service.

# Discovery and Career Planning

**Section 4.9 pg. 187-197**

Section	Summary of Key Changes
Service Description	<ul style="list-style-type: none"><li>• Revised to align with federal definitions to ensure consistency with national best practices.</li><li>• Clarified how DCP is the foundational, person-centered first step in the customized employment process, specifically designed to help individuals achieve competitive integrated employment (CIE) or self-employment.</li></ul>
Reimbursable Activities	<ul style="list-style-type: none"><li>• Expanded and detailed activities.</li><li>• Emphasizes individualized job exploration based on participant goals, interests and abilities.</li></ul>
Limits	<ul style="list-style-type: none"><li>• Revised timeframe to a maximum of twelve (12) months of cumulative DCP with an expectation the participant has a completed Customized Employment Plan to guide job development in a competitive integrated setting.</li><li>• Goal: Accelerate the transition to employment and maintain participant momentum.</li></ul>
Authorization	<ul style="list-style-type: none"><li>• New process added to request services beyond 12-month limit.</li><li>• Providers to submit required supporting documentation (such as completed Discovery Profiles and Quarterly Reports that demonstrate how previously approved hours were used and what additional hours are needed for) to the CM for review by the unit and section supervisor.</li></ul>
Staff Qualifications	<ul style="list-style-type: none"><li>• Service Supervisors, Employment Specialists and Job Coaches must complete specialized training within the first year of providing employment services.</li><li>• Job coaches that deliver DCP must complete training on the Discovery Process within the first year of providing DCP.</li></ul>
Documentation	<ul style="list-style-type: none"><li>• Completed Discovery Profiles and Discovery Action Meeting documentation shall be uploaded to the Provider Portal (or submitted to the CM prior to FY 2027).</li><li>• Completed Customized Employment Plan shall be uploaded to the Provider Portal (or submitted to the CM prior to FY 2027) within thirty (30) calendar days of the Discovery Action Meeting.</li></ul>

# Individual Employment Supports

Section 4.11 pg. 204-213

Section	Summary of Key Changes
Service Description	<ul style="list-style-type: none"><li>Revised to align with federal competitive integrated employment (CIE) standards to formalize expectations for equal pay, advancement opportunities, and integrated work settings.</li></ul>
Reimbursable Activities	<ul style="list-style-type: none"><li>Expanded to include workplace and job analyses for customized, high-quality job matches and training on fade plan strategies.</li></ul>
Authorization	<ul style="list-style-type: none"><li>New process added to request services exceeding the 80-hour limit for job development per Plan Year (i.e. providers submit supporting documentation to the CM for review by unit and section supervisors).</li></ul>
Staff Qualifications	<ul style="list-style-type: none"><li>Service Supervisors, Employment Specialists and Job Coaches must complete specialized training within the first year of providing employment services.</li></ul>
Documentation	<ul style="list-style-type: none"><li>Job Coaching Fade Plan shall be uploaded to the Provider Portal (or submitted to the CM prior to FY 2027) and shared with the circle of support within the first quarter of job coaching.</li><li>Expanded on the information to be included in Quarterly Reports.</li></ul>

# Adult Day Health (ADH) Community Learning Service – Group (CLS-G)

## ***ADH***

Section 4.4 pg. 144-152

- The staffing ratios per tiers are the recommended ratios. The minimum participant to staff ratio cannot exceed 1 staff to 6 participants for any tier, with lower participant ratios if specified in the participant's ISP.
- Allowance for exceptions when a participant requires Private Duty Nursing during ADH services, for nursing tasks that cannot be delegated.

## ***CLS-G***

Section 4.7.1 pg. 160-165

The staffing ratios per tiers are the recommended ratios. The minimum participant to staff ratio cannot exceed 1 staff to 3 participants for any tier, with lower participant ratios if specified in the participant's ISP.

# Community Learning Service – Individual (CLS-Ind)

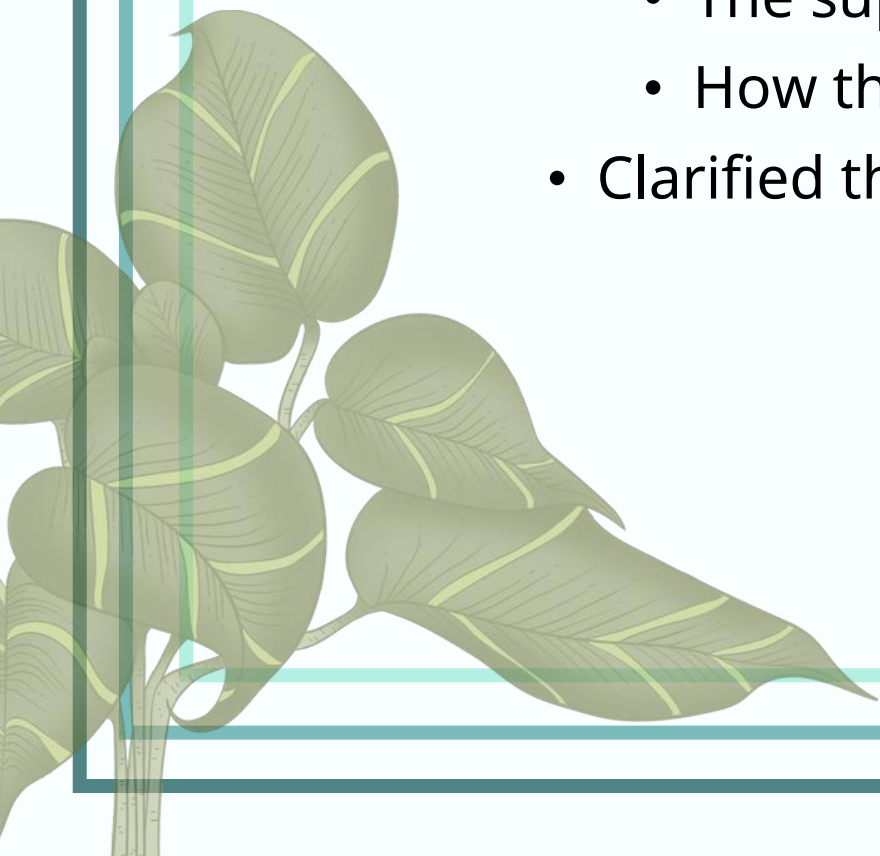
Section 4.7.2 pg. 166-177

- Clarified that there are no enhanced staffing ratios of 2:1 and 3:1 under Consumer-Directed.
- Clarified that CLS-Ind may not be used to transport participants to and from medical appointments.
- Clarified that out-of-state travel is limited to fourteen (14) calendar days without any exceptions.
- Relocated exception for CLS-Ind to be provided by a member of the ResHab household from the Authorization section to the Limits section.

# Personal Assistance/Habilitation (PAB)

Section 4.13 pg. 216-226

- Clarified that there are no enhanced staffing ratios of 2:1 and 3:1 under Consumer-Directed.
- Clarified that PAB services in an acute-care hospital setting must be approved in the ISP prior to service delivery. The ISP will document:
  - The services to be provided through PAB;
  - The supports to be provided by the hospital; and
  - How the services and supports differentiate.
- Clarified that out-of-state travel is limited to fourteen (14) calendar days without any exceptions.



# Personal Care Assistance (PCA)

Section 4.14 pg. 227-233

PCA includes a range of assistance that allows a participant to age in place, without any habilitation, training, or skill-building components, provided in the participant's own home or family home.

PCA assists a participant who has been assessed to no longer have the ability to participate in habilitative services in the home for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and supports aging in place. For example, individuals who are:

- aging in place and whose care needs have shifted towards personal care, health, or comfort support;
- diagnosed with an advanced/progressive or terminal illness, including those receiving hospice or palliative care;
- confined to a bed or medically fragile;
- recovering from acute illness/injury; or
- experiencing worsening dementia.



# Residential Care Supports (RCS)

Section 4.17 pg. 243-250

RCS is personal care and supportive services , without habilitation, for participants who reside in a licensed/certified setting.

RCS assists a participant who has been assessed to no longer have the ability to participate in habilitative services in the home for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and supports aging in place. For example, individuals who are:

- aging in place and whose care needs have shifted towards personal care, health, or comfort support;
- diagnosed with an advanced/progressive or terminal illness, including those receiving hospice or palliative care;
- confined to a bed or medically fragile;
- recovering from acute illness/injury; or
- experiencing worsening dementia

RCS is available in 3 tiers and will be authorized based on the participant's Supports Intensity Scale-based level

# Respite

Section 4.19 pg. 259-266

- Clarified that Respite Daily is not subject to EVV because the service is provided in a licensed/certified setting.
- Clarified that Respite is not allowed to be provided out-of-state or out-of-country.
- Added a limit of 31 days for Respite Daily, in line with 760 hour limit for Respite.
- For primary caregivers who are also the participant's DSW providing PAB or CLS-Ind, alternative options will be assessed before considering the authorization of Respite.



# Training and Consultation (T&C)

Section 4.21 pg. 271-286

## ***T&C***

- Inter-island T&C is limited to 4 hours for screening and an additional 4 hours for ongoing T&C.
- The Inter-island T&C rate includes the time and expenses for travel to a neighbor island

## ***T&C - Behavior***

- T&C by a Behavior Analyst may be provided in an acute-care hospital setting to provide transitional services to support successful return to the community.
- Clarified authorization process.

## ***T&C – Environmental Accessibility Adaptations (EAA)***

- Changed authorization amount from 20 hours to 25 hours.



# Vehicle Modifications (VM)

Section 4.22 pg. 291-295



- Routine maintenance of the vehicle modification is part of the VM service.
- Clarified the difference between repairs to a vehicle modification that was purchased using Waiver funds and modifications that were purchased without Waiver funds.
- Changed the maximum cost of vehicle modifications from \$36,000 to \$70,000.



# Changes to Service Limits

## ***Additional Residential Supports (ARS)***

Section 4.3 pg. 140-143

Changed definition of short-term from 60 days to 90 days.

## ***Environmental Accessibility Adaptations (EAA)***

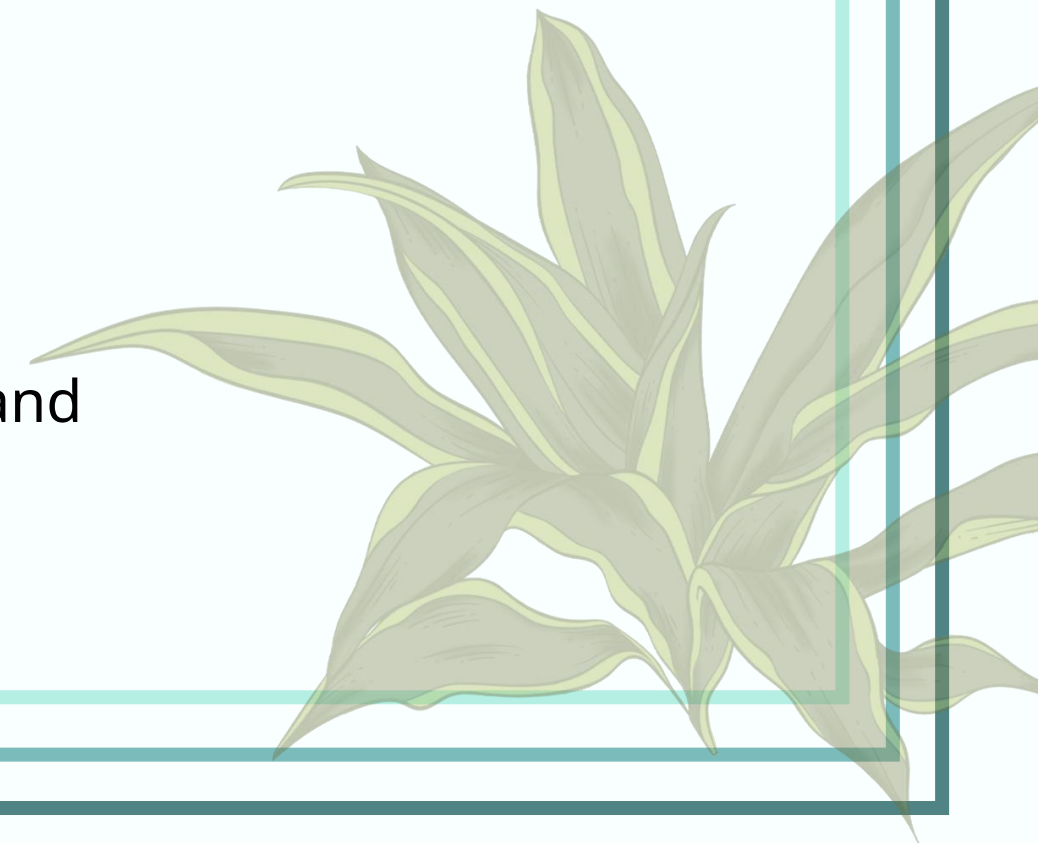
Section 4.10 pg. 196-201

Added allowance for exceptions of modifications that exceed the \$10,000 and \$45,000 limit.

## ***Private Duty Nursing (PDN)***

Section 4.16 pg. 237-242

Changed the maximum average hours per day from 8 hours to 10 hours and increased the day limit from 30 days to 60 days.



# Other Clarifications

## ***Non-Medical Transportation (NMT)***

Section 4.12 pg. 212-215

NMT may not be used to transport participants to and from medical appointments.

## ***Personal Emergency Response System (PERS)***

Section 4.15 pg. 234-236

Expanded service to adjust for current and evolving technology.

## ***Residential Habilitation (ResHab)***

Section 4.18 pg. 251-258

ResHab may not be provided on the same day as another daily service, such as Respite Daily and Residential Care Supports.





*Thank you*



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