B.5 Benefits and Services

In 2008, the Hawai'i *Going Home Plus* demonstration participants will transition from the institution directly into one of Hawai`i's five Section 1915c home and community-based services (HCBS) waiver programs on the day of discharge from the facility. These five are the Developmentally Disabled/Mentally Retarded, Nursing Home Without Walls, Residential Alternatives Community Care Program, Medically Fragile Community Care Program, or the HIV Community Care Program. Each waiver has sufficient slots available under the cap; the state will submit an amendment to increase the number of slots if waiver enrollment approaches the approved cap. In February 2009 when Hawaii's Quest Expanded Access (QExA) 1115(a) managed care demonstration starts, beneficiaries of four (4) waiver programs will be transitioned to receive their home and community based services (HCBS) services through the QExA program. Under QExA, the HCBS services for four (4) of the waiver programs administered by the Department of Human Services (DHS) are consolidated as a unique HCBS service package. These four (4) waiver programs transitioning to QExA are Nursing Home Without Walls, Residential Alternatives Community Care Program, Medically Fragile Community Care Program, and the HIV Community Care Program. DD/MR waiver participants will continue receiving HCBS services through the 1915c waiver. There are no plans to initiate any new 1915(c) waiver programs. Table B.5.1. provides a description of the 1915c waiver programs and the administering agency.

Table B.5.1. Description of Hawai`i's Waiver Programs.

Hawai'i's 1915© Waiver Programs	Administration	Description
Developmentally Disabled/ Mentally Retarded (DDMR) (ID #0013)	Department of Health (DOH)	Developmentally Disabled and Mentally Retarded individuals of all ages, statewide, who are ICFMR level of care (LOC).
Nursing Home Without Walls (NHWW) (ID#0057)*	Department of Human Services (DHS)	Individuals of all ages, statewide, who are Nursing Facility (NF) LOC and live at home
Residential Alternatives Community Care Program (RACCP) (ID#0014)*	Department of Human Services (DHS)	Individuals, statewide, who are 18 years old or older, NF LOC, living in Expanded-Adult Residential Care Homes, Adult Foster Homes and Assisted Living Facilities
Medically Fragile Community Care Program (MFCCP) (ID#401395) *	Department of Human Services (DHS)	Individuals up to age 21, statewide, who are Sub-acute or Skilled Nursing Facility LOC (with 50 points) statewide
HIV Community Care Program (HCCP) (ID#00182) *	Department of Human Services (DHS)	Individuals of all ages, statewide, who are NF level of care, live at home and have an HIV diagnosis

* Waiver programs to be consolidated under the QExA 1115 demonstration

After the 365th day of the *Going Home Plus* demonstration period, participants will continue to receive HCBS in the same 1915c waiver program or through their Hawai`i QExA Section 1115 (a) Medicaid Demonstration managed care plan as long as they continue to meet the eligibility requirements of the applicable program. The QExA program is expected to be operational in February 2009. Health plan selection by the State's Aged, Blind and Disabled (ABD) Medicaid beneficiaries is planned for October 2008.

Service Delivery System: Fee for Service for all five 1915(c) waiver programs until the QExA is implemented (11/08).

Effective February 2009, four of Hawai'i's existing Section 1915 © waivers (Nursing Home Without Walls, Residential Alternatives Community Care Program, Medically Fragile Community Care Program and the HIV Community Care Programs) will transition to a capitated managed care delivery system under Hawai'i's new QExA Section 1115 (a) demonstration program. These Medicaid beneficiaries will receive all their primary and acute care services as well as institutional care and HCBS long term care through a QExA health plan. Under QExA, the State's 1915(c) waiver services for these four waivers will be consolidated under one HCBS benefit package.

DD/MR waiver participants will receive capitated primary and acute care services through QExA. However, the DD/MR 1915c waiver program will continue to be operated in the Fee for Service environment through the approved five year waiver renewal period (2006- 2011). Hawai'i's ICF/MR facilities and the DD/MMR Targeted Case Management Services will also remain in the Fee for Service delivery system.

Qualified Waiver Services

Prior to managed care:
Each of Hawai'i's five 1915c waiver programs offer very comprehensive service packages. The qualified waiver services for each of Hawai'i's five 1915c waiver are illustrated in Table B.5.2. The Service descriptions are located in Appendix E. The diagram of the pre and post QExA waiver system is in Appendix F.

Table B.5.2. Description of Qualified Waiver Services.

	1915(c) WAIVER PROGRAMS				
WAIVER SERVICES	**DDMR**	**NHWW**	**HCCP**	**MFCCP**	**RACCP**
Adult Day Health	X	X	X	X	
Assistive Technology	X				
Assisted Living					X
Attendant Care				X	
Case Management		X	X	X	X
Chore	X				

WAIVER SERVICES	DDMR	NHWW	HCCP	MFCCP	RACCP
Community Care Foster Homes					X
Counseling and Training		X	X	X	
DDMR Emergency Services	X				
Environmental Accessibility Adaptations (EAA)	X	X	X	X	
Home Delivered Meals	X	X	X		
Home Maintenance		X	X	X	
Medically Fragile Day Care				X	
Moving Assistance		X	X	X	
Non-Medical Transportation	X	X	X	X	
Personal Assistance		X	X	X	X
Personal Assistance/Habilitation (PAB)	X				
Personal Emergency Response System(PERS)	X				
Private Duty Nursing		X	X		X
Residential Care					X
Residential Habilitation	X				
Respite Care	X	X	X	X	X
Skilled Nursing	X				
Special Medical Equipment & Supplies	X	X	X	X	X
Supported Employment	X				
Training and Consultation	X				
Vehicular Modifications	X			X	

For all five waiver programs, case management is separate from the provision of direct waiver services, in other words, case managers do not provide any of the waiver services. In Hawai`i, all waiver participants receive case management services under the following mechanisms.

- DD-MR. Targeted case management under the state plan provided by DOH State employees.
- MFCCP. EPSDT case management under the state plan for sub-acute level participants. Waiver case management service for SNF level participants. MFCCP case management is all provided by contracted agencies.
- NHWW. Waiver service provided by State DHS employees and contracted agencies.
- HCCP. Waiver service provided by contracted agencies and State DHS employees.
- RACCP. Waiver service provided by contracted agencies.

The majority of the contracted waiver case managers for MFCCP, NHWW, HCCP and RACCP are expected to contract with the QExA health plans.

Upon implementation of Hawai’i’s QExA 1115 Managed Care Demonstration, the DD/MR waiver HCBS package and provider network will remain unchanged. The consolidated HCBS package for the four waiver programs under QExA is shown in the grid below. All previously approved 1915c waiver services have been included in the consolidated QExA HCBS benefit. When QExA starts, HCBS case management services will be provided as follows.

- DD/MR case management services will remain fee for service under State Plan Targeted Case Management, provided by DOH State employees.
- QExA health plans will use HCBS case managers/service coordinators that are contracted agencies, contracted individuals and health plan employees. MFP participants, who will not be in the DD/MR waiver, will be offered a choice of HCBS case managers with signed health plan contracts. The MFP case manager, as a QExA plan contractor or employee, will be authorizing all Qualified Waiver, Demonstration and Supplemental Services.

Table B.5.3. Consolidated HCBS Package Under QExA 1115(a) Demonstration.

Authority	1915 (c)	1115(a)
Name of Program	DD/MR Waiver (Program ID#-0013) Home & Community-Based Services for Persons with Developmental Disabilities/Mental Retardation	QUEST Expanded Access (QExA) <u>Combined former 1915c waiver programs services</u>: ▪ Nursing Home Without Walls (NHWW) ▪ HIV Community Care Program (HCCP) ▪ Residential Alternatives Community Care Program (RACCP) ▪ Medically Fragile Community Care Program (MFCCP)
Qualified Waiver/HCB Services	•Adult Day Health •Residential Habilitation •Personal Assistance/Habilitation (PAB) •Chore •Respite •Skilled Nursing •Environmental Accessibility Adaptations •Personal Emergency Response System (PERS)- •Supported Employment •Non-Medical Transportation •DDMR Emergency Services •Specialized Medical Equipment & Supplies •Assistive Technology •Vehicular Modifications •Training and Consultation	•Case Management •Adult Day Health •Adult Day Care •Attendant Care •Counseling and Training •Environmental Accessibility Adaptations (EAA) •Home Delivered Meals •Home Maintenance •Medically Fragile Day Care •Moving Assistance •Non-Medical Transportation •Personal Assistance •Private Duty Nursing •Personal Emergency Response System (PERS) •Respite Care •Special Medical Equipment & Supplies •Community Care Foster Homes •Residential Care (Expanded) •Assisted Living

Table B.5.4. Qualified Waiver Services: After QExA is Implemented

QUALIFIED WAIVER/HCB SERVICES	DD/MR 1915C	QExA
Adult Day Health	X	X
Assistive Technology	X	
Assisted Living		X
Attendant Care		X
Case Management		X
Chore	X	
Community Care Foster Homes		X
Counseling and Training		X
DDMR Emergency Services	X	
Environmental Accessibility Adaptations (EAA)	X	X
Home Delivered Meals	X	X
Home Maintenance		X
Medically Fragile Day Care		X
Moving Assistance		X
Non-Medical Transportation	X	X
Personal Assistance		X
Personal Assistance/Habilitation (PAB)	X	
Personal Emergency Response System(PERS)	X	
Private Duty Nursing		X
Residential Care		X
Residential Habilitation	X	
Respite Care	X	X
Skilled Nursing	X	
Special Medical Equipment & Supplies	X	X
Supported Employment	X	
Training and Consultation	X	
Vehicular Modifications	X	X

Demonstration Services

Under the *Going Home Plus*, Hawai`i will offer three demonstration new services: Transition Coordinators, Virtual Care Office (Telehealth), and a Training Institute

Transition Coordinator. The transition coordinator will provide relocation assistance and intensive service coordination activities to assist nursing facility, hospital and ICF-MR residents to transition to community settings of their choice. Transition coordinators will provide additional oversight and coordination activities for *Going Home Plus* participants during a transitional period up to six months following a return to the community. This period may be extended or restarted during the demonstration period on a case-by-case basis (e.g. move from foster home to apartment) Transition coordination services will be provided to all *Going Home Plus* participants. There will be six transition coordinators during the first year of the project, with an additional two added in 2009 and two more added in 2010. Transition coordinator duties include but are not limited to the following:

- Outreach to facility staff and administrators to explain *Going Home Plus*.
- Meet with potential participants, families and legal representatives to explain the program, Medicaid 1915c waiver/HCBS and non-waver services and supports.
- Provide written educational materials.
- Confirm eligibility for *Going Home Plus.*
- Perform a comprehensive assessment of health, social and housing needs.
- Develop a transition plan together with participant/family/legal representative and appropriate facility staff.
- Housing: Develop housing options with each participant.
    - Assist with housing choices, applications, waitlists follow-up, roommates and trial visits
    - Secure housing for all participants
- Assist participant and facility staff to identify facility tasks to accomplish in order to move/ prior to move.
    - Medication revisions
    - Changes in therapies to increase independence/participation in self care, mobility and other required functional capability
    - Diet revision, exercise, or weight loss plans
    - Knowledge about own needs and self care
    - Caregiver training and skills competency evaluation
- Assist participant with community arrangements needed to move.
    - Obtain durable medical equipment, assistive technology, and medical supplies
    - Arrange for home modifications
    - Identify medical, dental, specialty, and pharmacy providers
    - Secure financial assistance, food stamps, and Medicaid eligibility updates
    - Arrange housing payments including rent set up
    - Arrange security, utility, and phone deposits
    - Prepare household including cleaning, moving property, purchasing furniture, household items, and food
    - Establish a bank account
    - Describe transportation options and how to access

- Assist participant with required paperwork.
- Coordinate meeting with waiver/HCBS case manager, participant/family/ legal representative and other requested individuals/clinicians to develop the waiver/HCBS service plan for community living and identify service providers.
- Arrange for the services in the service plan.
- Ensure services/equipment/supplies/moving day transportation are in place prior to facility discharge.
- Help participant move on discharge day.
- Conduct initial MFP Quality of Life survey.
- Assist with transition in the community.
- Conduct post transition monitoring visits or contacts for at least three months: at least once a week for the first month, twice a month for the second month, and once a month for the third month or as requested by the participant.
- Assist participant with problem solving/ dependency and isolation issues/consumer directed services/supports/ community inclusion.
- Assess caregiver status and assist with problem solving/needed training.
- Coordinate with waiver/HCBS case manager to address needed revisions to the service plan.
- Maintain accurate, comprehensive, confidential program records.
- Participate in monthly *Going Home Plus* team meetings to identify successful strategies and barriers for improvement such as participant identification, facility participation, participant/family /legal representative education for program acceptance, and housing and service provider availability.

Provider Qualifications. Transition coordinators will meet the same qualifications as waiver case managers: Hawai’i licensed registered nurse or Hawai’i licensed social worker, with two years experience preferably with care coordination responsibilities and is familiar with long term care and home care, and other individuals possessing a bachelors degree in human/social service related fields with relevant training and experience, under the direct supervision of the Licensed Social Worker or Registered Nurse Case Manager.

Virtual Care Office. (Telehealth) will enable the collection of medical/behavioral data, transmission and communication of medical/behavioral information, and consultation with physicians and specialists. This service will be available for *Going Home Plus* participants who have complex medical or behavioral problems. The telehealth service will offer two virtual systems: remote patient monitoring and video monitoring.

Remote patient monitoring. This telehealth system is used to monitor vital signs, report certain labs (i.e. blood sugar) and provide timely medical reminders (no video component). The system collects vital signs (weight, blood pressure, heart rate, etc.) and other data and transports that information to a central database. The system alerts the clinician when information is out-of-range or missing.

Video Monitoring. For the video house call, this system uses a video camera. A digital stethoscope may be added for medically complex participants. The clinician can remotely

manipulate the camera pan, tilt, or zoom. Using the camera, the clinician can view (and document by snapping digital still photos) specific areas of concern.

- The system may be used to view and treat buttock rash, fungal dermatitis, pressure dermatitis from a PEG flange, irritated granulation tissue at a tracheostomy stoma, a minor bleed on a tracheostomy pad, pulmonary bleeding from tracheal suction, and other skin infections.
- Tele-mental health and support services may be used to provide assessments and evaluations, crisis intervention, medication management, family visits, family and consumer support groups, health education, supportive counseling and life skills education/training.
- Additional uses for virtual monitoring and televideo services that will assist the MFP participant to remain in the community (such as extended physical, speech or occupational therapies), lengthen the stay in a particular community residence, reduce the number of rehospitalizations, ER visits or emergency transports between islands will be evaluated and implemented as appropriate during the demonstration period.

When clinicians log into the Virtual Care Office website, they will be presented with their list of *Going Home Plus* participants. For HIPAA privacy purposes, each clinician may only view his/her participants. Participants receiving behavioral service intervention would be linked with licensed mental health specialists via a video link-up from a secure facility.

The specific equipment (digital scale, blood pressure cuff, spirometer, pulse oximeter, glucometer, camera, etc.) for the virtual system will be identified and agreed upon by the participant, their medical team and caregivers. The Discharge Planner or Transition Coordinator will be responsible for ensuring the equipment is in the home at the time of discharge and that all parties have been trained to use the equipment prior to discharge. The Transition Coordinator and the waiver/HCBS case manager will be trained to explain the system, the various components, and how it will work including any health benefits and risks of use to the providers, participants and /or their caregivers. A plan to remove the equipment (estimated at six months) from the home will be agreed upon by the participant, their medical team, caregivers and transition coordinator and/or case manager. This period may be extended or restarted during the demonstration period as agreed upon by the participant, case manager, medical team and caregivers.

Provider Qualifications. Independent registered nurse, Home Care Agency, Hospital, or Nursing Home. Nursing visits up to 12 visits will be covered when it is not covered as a Medicaid home health benefit.

***Nurse Help Line*.** This is a 24/7 on-call nurse information line that will be offered to *Going Home Plus* participants until the Medicaid 1115a managed care plans for the aged, blind, and disabled launched in February 2009. At that point, all Medicaid participants will have access to a nurse information help line through their established Medicaid managed care health plan.

MFP participants can call the nurse information line to ask health advice and speak with trained registered nurses who will provide care recommendations using clinical protocols and guidelines to determine the appropriate level of response required. A daily report will be provided to

designated MFP program providers that includes the date and time of each call, responder name and title, participant question, response, the referrals, follow up provided.
Provider Qualifications: 24/7 Medical Call Center, Home Care Agency or Managed Care Organization

Training Institute - Grant funds will be used to establish a "training institute" to develop the training curriculum to provide the necessary training and support to the caregivers for persons with medical conditions and behavioral health issues. A training curriculum will be adopted in the following eight subject areas: behavioral interventions, crisis management, wound care, palliative care, obesity, vent care, home dialysis, and foster level three skills. Resource individuals will be identified in the community and their curriculum materials adopted or adapted as needed.

Resource trainers will be contracted to provide the service on an as-needed basis to individual caregivers. This training could occur prior to transition when the need for enhanced caregiver skills in a particular area is identified. Or, it can be provided after transition during the 365 days of eligibility as new needs are identified. Based on discussions with discharge planners in the community, the projections were made for the need for training in each of the categories. The training sessions will vary by the length of time needed to make the caregiver comfortable with providing the service

Provider Qualifications. The provider qualification will vary depending on the curriculum being delivered, but will include licensed and certified professional registered nurses, social workers, behavioral specialists, psychologists, psychiatrists, physicians, pharmacists, dieticians, physical therapists, occupational therapists and speech therapists.

Supplemental Demonstration Services (Transitional Services)

In addition, all *Going Home Plus* participants will be eligible for "Supplemental Demonstration Services. These are items, goods and services needed to allow the institutionalized individual to establish a community residence. Supplemental services may be provided one time during the MFP demonstration and may not be accessed for subsequent moves within the community without DHS authorization. Billing for transitional services may begin the day the individual moves to the community. These start-up funds can be used for the following

- Housing coordination, housing locator services and roommate locator services
- Trial visits to qualified community residences
- Housing deposits
- Utility hook-ups & deposits
- Essential furniture, appliances, household items and clothing
- Initial food stocking
- Financial Services

Other items, goods and services may be approved by DHS when deemed necessary for the health and welfare of the participant. Supplemental Demonstration services for community transitions do not include monthly rent or mortgage payments, televisions, cable or recreation expenses.

DD/MR waiver participants will be eligible for the following additional Supplemental Demonstration Services: moving assistance and home maintenance. These services had previously been included in the DD/MR waiver package but were removed based on lack of utilization. Use will be monitored during the *Going Home Plus* to evaluate the need for a waiver amendment.

Reimbursement. Transitional services total costs may not exceed $5,000 per person for the transitions from the institution into the *Going Home Plus* program.