Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The Waiver renewal application includes the implementation of regulatory changes due to the Access Rule requirements, proposed North Dakota administrative code changes and internal process including updated language and process of completion of the comprehensive assessment and person-centered practices.

The Access Rule changes include the strengthening of person-centered practices and access to care, updates to assessment core and supplemental elements, care planning, case management, grievances, and reporting transparency.

The clarification of internal processes changes in the renewal application will allow for program changes to be implemented and clarified in relations to the proposed Administrative Code changes include:
•Requiring the annual comprehensive assessment and person-centered plan of care to be completed annually in the HCBS participants home where services are delivered, when there are significant changes in the participants needs, and upon request of the participant.
•Update qualified service provider enrollment and qualifications and standards as required under NDAC 75-03-23-07,
•Update Residential Habilitation and Community Support Provider requirements as established in NDAC 75-03-23-18.

Internal processes and other updates
• Include senior companionship providers as eligible to provide the service verified by national senior companionship approval under non-medical transportation.
• Update the internal processes for program integrity and monitoring.
• Update the Factor D Derivation of estimates for the estimated number of users, and average units per user based on actual data from state fiscal year (SFY) 2026. These adjustments were needed due to unprecedented growth in waiver participants from SFY 2021 to SFY 2026, the implementation of the services of Residential Habilitation, Community Support and Waiver Personal Care and the SMA administratively claiming for regulatory case management.
• Monthly waiver services cannot exceed $37,000 for the highest nursing home rate in SFY 2025, inflated by the 2026 CPI of 3.7%, inflated each year with legislative approved rate changes, if a rate change occurs.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **North Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under

the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Medicaid Waiver for Home and Community Based Services

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: ND.0273
Draft ID: ND.001.07.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☑ **Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under section 1915(b) of the Act.

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose: The Medicaid Waiver for Home and Community Based Services provides service options for a continuum of home and community based services in the least restrictive environment.

Goals and Objectives: The goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. In order to successfully meet the mandate, a consumer-centered, affordable delivery system has been established for delivery of in-home services to the elderly and physically disabled.

To accomplish these goals, an array of services is offered through the waiver. A system has been established to assess the needs of participants, implement a care plan, monitor the progress of the care plan, and re-evaluate consumer needs on a regular basis.

Partnerships: This system involves a partnership between the local Human Service Zones, the North Dakota Department of Health and Human Services, informal networks, and participants/family members. Advocates for consumers have played a significant role in identifying gaps in current Waiver services.

When applicable, other State agencies or other Department of Health and Human Services Divisions have participated in discussions in establishing and maintaining a quality system. They have played a crucial role in the decision-making process. Some of the other State agencies and Divisions that have contributed to identifying service needs are: The Department of Health Division; Protection and Advocacy; ND Department of Health and Human Services Medical Services Division, Developmental Disabilities Division, Behavioral Health Division, Vocational Rehabilitation, and the Legal Services Division.

Several non-governmental entities provided input including: Independent Living Centers, current and potential participants, family members, and other service providers.

Service Delivery System: The service delivery system includes individual and agency service providers.

Service providers are enrolled through the Department of Health Human Services. Service providers must display skills competency or provide current licensing/credentialing (when applicable).

The administrative/regulatory case management is provided by HCBS Case Managers employed by ND Department of Health and Human Services throughout 19 zones across the state.

The service array available under the waiver is provided by qualified service providers (QSPs) who are enrolled with the department and authorized to provide the services. QSP enrollment books are available on the Department of Health and Human Services website. Interested parties may also request a copy of the enrollment book directly from the Department of Health and Human Services. Technical assistance is provided upon request.

The North Dakota Department of Health and Human Services, Aging Services Division which is part of the State Medicaid Agency will administer the Waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver,

the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ● **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ● **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- ● **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make

participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight

and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

On 11/13/2026 the state Medicaid agency's (SMA's) sent a notice to all Tribal Chairman, Tribal Health Directors and IHS Representatives in ND notifying them of the SMAs intent submit to amend the HCBS waiver. Tribal organizations were notified that they can view the waiver on the DHS website or receive a copy upon request. The tribal consultation notification letter was also posted to the DHS website. The required 30-day public comment period will be from November 13, 2026, until 5 p.m. CT on December 13, 2026. SMA provides opportunities for public comment on the amendment in the following manner: 1) The waiver www.hhs.nd.gov/waivers and public notice is posted to the Department of Health and Human Services (DHHS) website https://www.hhs.nd.gov/events. The public notice is also posted in a public area at the Capitol. 2) A press release is issued statewide notifying the public via newspapers and other media outlets of the opportunity for public comment. The public notice and press release includes information on how to access the waiver application online or request a hard copy and contains information on how to submit public comments. On 8/19/2026 the Medicaid Medical Advisory Committee members were be notified of the State Medicaid Agency's intent to renew the HCBS waiver. On 9/8/2026, the SMA will met with tribal partners on the waiver renewal at the tribal consultation meeting.

The public was able to provide public input as noted on the state's public notice website:
Email: dhshcbs@nd.gov
Phone: (855) 462-5465 or 711 (TTY) (text telephone)
Fax: (701) 328-8744
Mail: Adult and Aging Services Section/HCBS
Health and Human Services
1237 W. Divide Ave. Suite 6
Bismarck, ND 58501

Public input for the waiver renewal included seeking comments about a draft, conducting focus groups with affected parties (waiver participants, families, providers, and other stakeholders) about the scope and nature of services offered, establishing a standing advisory group or committee to assist with development of the waiver).

The SMA conducted multiple public comment opportunities throughout the year including discussion during the public meetings with stakeholders. Public input meetings include both in-person and virtual meetings to afford stakeholders multiple opportunities to provide input and feedback on waiver services. The public input meetings include a presentation by the SMA discussing information on long term services and supports available in the state, current utilization of services in the state. Additionally, the administrative language changes in the North Dakota Administrative Code (NDAC) includes in-person legislative committee hearings with opportunity for the public to comment and provide feedback on proposed changes. The public comment is collected from these public input meetings and used to evaluate any gaps in services or potential areas to expand. Additionally, stakeholders are provided with written information about long term services and supports along with ways public comment could be received after the public meetings were held. In February/March 2026 Public Input Meetings were held across the state to elicit feedback on what stakeholders would like to see changed in the waiver renewal. Additionally, the SMA presented information on the waiver renewal at the Money Follows the Person (MFP) External partner meeting on 8/18/2026.

The SMA will be presenting a second time at the Medicaid Advisory Council meeting, Tribal Consultation meeting and at the MFP External Partner meeting during the public comment period.

SMA has been working with tribal nation service providers and partners for over a year to identify gaps in the delivery of home and community-based services to tribal members. The proposed change in the amendment is expected impact to tribal members and other waiver participants by expanding access to home and community-based services with cultural support and advocacy.

Payment for waiver services is continually evaluated through public input meetings and has been evaluated by a provider rate study in 2023 to ensure the rates are sufficient to assure there are enough providers available to meet demand. Rates are adjusted through legislative action and waiver amendments when it is found that there needs to be adjustment to the rate to meet increase access to waiver services and availability of providers. There is no wait list for waiver services, and we currently have approximately 1500 agency and individual providers enrolled across the state.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by

Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Erber

First Name: Sandi

Title: HCBS Program Administrator

Agency: ND Department of Human Services

Address: Aging Services Division

Address 2: 1237 W Divide Ave Suite 6

City: Bismarck

State: **North Dakota**

Zip: 58501

Phone: (701) 328-8915 **Ext:** ☐ **TTY**

Fax: (701) 328-4875

E-mail: srerber@nd.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Dakota**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: North Dakota

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The North Dakota Department of Health and Human Services (DHHS) acknowledges that there are legal and stakeholder partnerships with the Indian Tribes in North Dakota. These partnerships have grown throughout the years and will continue to be an integral part of implementing the revisions set forth by the American Recovery & Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA).
It is the intent of DHHS to consult on a regular basis with the Indian Tribes established in North Dakota on matters relating to Medicaid and Children's Health Insurance Program (CHIP) eligibility and services, which are likely to have a direct impact on the Indian population. This consultation process will ensure that Tribal governments are included in the decision making process when changes in the Medicaid and CHIP programs will affect items such as cost or reductions and additions to the program. The North Dakota Department of Health and Human Services shall engage Tribal consultation with a State Plan Amendment, waiver proposal or amendment, or demonstration project proposal when any of these items will likely have a direct impact on the North Dakota Tribes and/or their Tribal members.

Direct Impact:
Direct impact is defined as a proposed change that is expected to affect Indian Tribes, Indian Health Services (IHS) and/or Native Americans through: a decrease or increase in services; a change in provider qualifications; a change in service eligibility requirements; a change in the compliance cost for IHS or Tribal health programs; or a change in reimbursement rate or methodology.

Consultation:
When it is determined that a proposal or change would have a direct impact on North Dakota Tribes, Indian Health Services or American Indians, the North Dakota Department of Healthe and Human Services will issue written correspondence via email to Tribal Chairs, Tribal Healthcare Directors, the Executive Director of the Indian Affairs Commission, Indian Health Services Representatives and the Executive Director of the Great Plains Tribal Chairmen's Health Board. In addition to the written correspondence, the Department may use one or more of the following methods to provide notice or request input from the North Dakota Indian Tribes and IHS.
a. Indian Affairs Commission Meetings
b. Interim Tribal and State Relations Committee Meetings
c. Medicaid Medical Advisory Committee Meetings
d. Independent Tribal Council Meetings

Ongoing Correspondence:
A web link will be located on the North Dakota Department of Health and Human Services website specific to the North Dakota Tribes. Information contained on this link will include: notices described below, proposed and final State Plan amendments, frequently asked questions and other applicable documents.

A specific contact at the North Dakota Department of Health and Human Services Medical Services Division, in addition to the Medicaid Director, will be assigned for all ongoing Tribal needs. This contact information will be disseminated in the continuing correspondence with the North Dakota Tribes.

Content of the written correspondence will include:
Purpose of the proposal/change
Effective date of change
Anticipated impact on Tribal population and programs
Location, date and time of face-to-face Consultation OR if Consultation is by written correspondence,
the method for providing comments and a timeframe for responses. Responses to written correspondence are due to the Department 30 days after receipt of the written notice.

Meeting Requests: In the event that written correspondence is not sufficient due to the extent of discussion needed by either party, The North Dakota Department of Health and Human Services, the North Dakota Tribes, or Indian Health Services can request a face-to-face meeting within 30 days of the written correspondence, by written notice, to the other parties. The SMA gathers input on HCBS rates via a survey process or public hearings that are held in every region of the State including reservation communities.

The public input is compiled & considered when determining budget & service delivery priorities. Waiver recipients are made aware of the QPS's rate when they choose their QSP. The rate for each service is also listed on the client's PCP. When LEG rate increases are approved, clients who have a recipient liability are informed in writing that the service costs will increase. The SMA maintains a QSP list https://www.directcarecareers.com/north-dakota-workers-registry that includes the rates by provider. This list is available to clients & the public via online database. Some rates are unique ie. Adult Foster Care (AFC) & Family Personal Care (FPC) to the client because they are based on the client's assessed needs. Due to confidentiality these rates are not

available to the public but are provided to the client & listed on their person-centered plan (PCP). ND has over 1500 enrolled QSPs statewide & we do not have a waiting list for waiver services.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- (●) **The waiver is operated by the state Medicaid agency.**

  Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

  - ( ) **The Medical Assistance Unit.**

    Specify the unit name:

    (Do not complete item A-2)

  - (●) **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

    Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

    Aging Services Division

    (Complete item A-2-a).

- ( ) **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

  Specify the division/unit name:

  In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

   The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight over the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities. The North Dakota Department of Health and Human Services is the single State Medicaid Agency which includes the Aging Services Division and Medical Services. Aging Services Division is responsible for the daily administration and supervision of the waiver, as well as issues, policies, rules and regulations related to the waiver. Oversight of waiver activities is assured through the Department's quarterly waiver coordination meetings which include representatives from Medical Services and other units administering waivers.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding

(MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

  The Department maintains a contract with Maximus to complete skilled nursing facility level of care determinations that ensures eligibility criteria are met for participation in the waiver.

  The Department maintains a contract with Noridian to conduct provider enrollment. SMA provides ongoing oversight and annual review of provider enrollment to ensure compliance with provider requirements.
- ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:

  [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

  Specify the nature of these agencies and complete items A-5 and A-6:

  [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Aging Services Division, North Dakota Department of Health and Human Services

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

HCBS Case Managers are reviewed every year by desk audit or on site. HCBS Case Managers are unaware of the files that will be chosen prior to the review. Onsite reviews include in-person or virtual client interviews with some of the identified audit sample. Each audit includes an exit interview, and the provision of technical assistance as it pertains to the review findings.

Maximus is monitored by daily reporting via web application, monthly reports from Maximus to the State Medicaid agency, input from HCBS Case Managers regarding service performance, weekly telephone contact with Maximus regarding contract components and input of screening into MMIS assuring timely completion of reviews.

SMA continues to use the information and data for the Quality Performance Measures provided by the contracted agency.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care waiver eligibility evaluation	☑	☑

Function	Medicaid Agency	Contracted Entity
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☐
Qualified provider enrollment	☑	☐
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants whose records reflect that the operational and administrative functions were carried out according to policy and procedures. N: Number of participants whose records reflect that the operational and administrative functions were carried out according to policy and procedures. D: Total number of participants reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data	Frequency of data	Sampling Approach*(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/5% Margin of Error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95% Confidence Level with a +/5% Margin of Error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Offsite record reviews will be conducted on a statistically valid number of waiver clients' care plans and assessments to assure Case Management entities manage waiver enrollments as required and assure that waiver requirements are met.

Statistical significance for the desk review of assessments/care plans will be determined by calculating a representative random sample of current waiver recipients based on credible parameters including a 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

State Medicaid Agency staff are responsible for addressing individual problems. Problems may be corrected by providing one-on-one or group training/education, clarifying/rewriting policy. The state maintains documentation that tracks training, policy changes and any other corrective actions or remediation needed to correct issues as they arise.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target*

group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☑	**Disabled (Other)**	18	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Additional Criteria for Disabled (Physical) -If under 65 an individual must be determined physically disabled by the Social Security Administration or by the State Review Team.

Additional Criteria for Disabled (other) - The disabled (other) group includes individuals with brain injury and dementia.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Once an individual turns 65 they are considered aged and are still eligible for the waiver if they meet all of the other eligibility criteria.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and

community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    Specify:

    The is set at $37,000 for the highest nursing home rate in SFY 2025 , inflated by the the 2026 CPI of 3.7%, inflated each year if a rate change occurs. Rates are published once per year. Current rates are available by contacting the Department of Health and Human Services Rate Setting Administrator.

    Care plans for all waiver recipients must be submitted to the State Medicaid agency (SMA) when services are initiated and every time services change thereafter. Reviewing the care plan and authorizing services includes assuring that the total cost of waivered services does not exceed the current highest monthly rate allowed to a nursing home within the rate setting structure of DHHS. SMA allows for reasonable modification to exceed the current highest monthly rate allowed to a nursing home for waivered services upon prior approval by Program Administration.

    All individuals are allowed to ask for a reasonable modification. The reasonable modifications requests are individually viewed, and a decision is made based on the facts presented and whether the person is at risk of institutional placement if the accommodation is not made.

    Programs and services administered and supervised by the department, directly or through contractual agreements, must be made available without regard to race, color, religion, national origin, age, political beliefs, disability, or status with respect to marriage.

- **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

- **Is adjusted each year that the waiver is in effect by applying the following formula:**

  Specify the formula:

- **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

A comprehensive assessment will identify the formal and informal service needs of the individual and provider availability. If the plan of care could not assure the health, welfare, and safety of the individual, services would be denied. The individual would receive appropriate notification of appeal rights.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☑ **Other safeguard(s)**

Specify:

Case management works with the individual and the person-centered planning team to develop a person-centered plan that addresses the health and welfare of the individual as required by NDAC 75-03-23. If there is an identified health, welfare and safety risk identified through the comprehensive assessment, a risk assessment and safety plan is developed. The risk assessment and safety plan includes documentation of the participants risks, participants action/inaction, the possible negative outcomes and alternative measures that may be implemented by the participant or formal and informal supports to ensure the continuity of services.

Case management services will assist the individual to identify other community resources or options. The case manager discusses the other community resources and options along with any referrals that the individual wishes to have made with the individual as part of the person-centered planning meeting. If the comprehensive assessment identifies that the formal and informal service needs of the individual and provider availability are not adequate to assure the health, welfare, and safety of the individual, the situation is staffed with program administration to determine if then services would be terminated. If it is determined that the individual's health, welfare and safety needs cannot be met, the individual would receive appropriate notification of appeal rights.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1559
Year 2	1793
Year 3	2062
Year 4	2371
Year 5	2727

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the waiver is offered to individuals based on the date of their application for the waiver; first-come, first-served basis.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **Section 1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- ☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☐ **Pregnant Women (42 CFR § 435.116)**
- ☐ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- ☐ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**
- ☑ **Medically needy in 209(b) States (42 CFR § 435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

Special home and community-based waiver group under 42 CFR § 435.217) *Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed*

- **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*
- **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

- **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

- **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

- **100% of FPL**
- **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR § 435.121**

    Specify:

  - ( ) **Optional state supplement standard**
  - (●) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify percentage:

    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:

  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:

  - ( ) **Other standard included under the state plan**

    Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

- ( ) **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

Specify the amount of the allowance (*select one*):

- ( ) **The following standard under 42 CFR § 435.121**

  Specify:

- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- (●) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

  Specify:

- ( ) **Other**
  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The state does not establish reasonable limits.**
- **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional state supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:

- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

  Specify formula:

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The state does not establish reasonable limits.**
- **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

Specify the entity:

Maximus

Other
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered, Licensed Practical, or Licensed Vocational Nurse

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care instrument used by the State to evaluate and reevaluate whether an individual needs services through the waiver is entitled the Level of Care (LOC) Determination form. The completed document must be approved by the Maximus to verify that the individual meets nursing facility level of care, as defined in North Dakota Administrative Code (N.D.A.C) 75-02-02-09.

The LOC form assesses the client's health care needs, cognitive abilities, functional status, and restorative potential.

Vendor applies the criteria established by the state. If the determination is appealed, the state determines the appeal.

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The case manager meets with the client and completes a functional assessment. They obtain collateral information as appropriate from family, medical professionals and provide this information to Maximus, which allows Maximus to complete the level of care determination. Once a determination is made, a copy of the determination response is forwarded to the case manager and is available to the Department via Maximus' website. Maximus is a contracted entity; the contract is monitored by a Medical Services Division Program Administrator.

The same process is required for initial or re-evaluations of level of care.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule *(select one)*:

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Case Managers are responsible to retain a schedule of when re-evaluations are due. Case Managers have access to a report that is available on Maximus' website to help them track the reevaluation dates of their cases. The State Medicaid Office runs a report each week of the level of care screenings that were approved by Maximus and enters the level of care screening dates into the MMIS system. The State Medicaid office also monitors level of care reevaluations semi-annually as part of our quality improvement process to assure that all level of care evaluations are current. If a problem is found, the State Medicaid Agency contacts the Case Manager directly to correct the issue.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Case management entities retain copies of the instrument and approvals/denials of screenings. Maximus, retains records that are available to the Department via their website. The website is available to the State Medicaid agency and allows us to electronically generate reports and documentation of NF LOC screening and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B-1 Number and percent of applicants for whom there is reasonable indication that services may be needed in the future that received an evaluation of level of care (LOC). N: Number of applicants for whom there is reasonable indication that services may be needed in the future that received an evaluation of level of care. D: Total number of applicants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
A report generated from DDM Ascend Management Innovations, LLC. that lists completed screenings will be verified against a State generated MMIS report that identifies all enrolled waiver participants.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

A report generated from DDM Ascend Management Innovations, LLC. that lists completed screenings will be verified against a State generated MMIS report that identifies all enrolled waiver participants.		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B-2 Number and percent of level of care (LOC) determinations made on the correct form and the LOC criteria applied appropriately. N: Number of level of care (LOC) determinations made on the correct form and the LOC criteria applied appropriately. D: All LOC determinations reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95% Confidence Level with a +/- 5% Margin of Error.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of initial and annual level of care (LOC) determinations made by a qualified reviewer. N: Number of annual LOC determinations made by a qualified reviewer. D: All annual level of care determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDM Ascend report that lists the names of the reviewer, who completed each screening, will be verified against the reviewer's credentials that are required to be submitted to the State.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: DDM Ascend report that lists the names of the reviewer, who completed each screening, will be verified against the reviewer's credentials that are required to be submitted to the State.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The State requires all screenings to be completed on a standardized tool. The State contracts with Maximus. to complete all LOC screenings. The contract requires that all LOC screenings be performed by a registered nurse or by licensed practical nurses, with at least three years of experience in behavioral health and three years of geriatric experience, receiving direct supervision from a registered nurse with a minimum of three years of psychiatric and three years of geriatric experience.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

It is the responsibility of State staff to address individual problems which are resolved through various methods which may include but are not limited to: providing one-on-one technical assistance, group training, recoupment of funds, amending the contract, or termination of contract for non-compliance if necessary. Documentation is maintained by the State that describes the remediation efforts.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State Medicaid agency requires the case management entity to obtain signatures of applicants/consumers or legal representatives on the following forms: Application for Service SFN 1047, and the web-based Home and Community Based Services (HCBS) Person-Centered Plan of Care.

These documents allow the applicant/consumer or legal representative to indicate that they have agreed to choose waiver services versus institutional care; that they have chosen their service provider(s), have accepted a plan of care; and that they have been informed of the right to appeal if dissatisfied or not in agreement with services.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The case management entity maintains all forms in the case file and in the web-based case management system. The State Medicaid Agency has access to the individuals Person Centered Plan of Care through the web-based case management system.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

When a consumer is unable to independently communicate with a case manager or State reviewer, a family member or community interpreter is present.

The Department has a limited English proficiency implementation plan that provides guidelines and resources. The plan is posted on the Department's website.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Care**		
Statutory Service	**Adult Residential Care**		
Statutory Service	**HCBS Care Coordination**		
Statutory Service	**Homemaker**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite Care**		
Statutory Service	**Supported Employment**		
Statutory Service	**Waiver Personal Care**		
Other Service	**Adult Foster Care**		
Other Service	**Chore**		
Other Service	**Community Support Service**		
Other Service	**Community Transition Services**		
Other Service	**Companionship Service**		
Other Service	**Emergency Response**		
Other Service	**Environmental Modification**		
Other Service	**Extended Personal Care**		
Other Service	**Family Personal Care**		
Other Service	**Home Delivered Meals**		
Other Service	**Non-Medical Transportation**		
Other Service	**Specialized Equipment & Supplies**		
Other Service	**Supervision**		
Other Service	**Transitional Living**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Day Care is a community-based service offered within an approved group setting designed to meet the needs of functionally impaired adults. It is a structured, comprehensive service that provides a variety of social and related support services in a protective setting during a part of a day. Meals provided as a part of these services shall not constitute a full, nutritional regimen (3 meals/day). Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring for an impaired member at home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Minimum of 3 hours per day through a maximum of 10 hours per day, on a regularly scheduled basis, for one or more days per week.

Non-medical transportation may be included as a part of this service and is included in the rate.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individuals & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Individuals & Agency

Provider Qualifications

License *(specify):*

Agency only - N.D.C.C. 23-16; N.D.A.C. 33-07-01; 33-07-03.1; N.D.A.C. 33-03-24.1-10

Certificate *(specify):*

Other Standard *(specify):*

Individual - Enrolled Qualfied Service Provider (QSP) N.D.A.C. 75-03-23-07
Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment , and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Adult Residential Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A residential program specializing in care of individuals with chronic moderate to severe memory loss or an individual who has a significant emotional, behavioral, or cognitive impairments and needs the services of: independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building. Or the individual may require protective oversight and supervision in a structured environment that is professionally staffed to monitor, evaluate and accommodate an individual's changing needs. It is also a service in which assistance with ADL's/IADL's, therapeutic, social, and recreational programming is provided. Care must be furnished in a way that fosters the maintenance or improvement, as appropriate, in independence of the recipient.

Personal care/assistance or other similar services may be a component part of residential habilitation services but may not comprise the entirety of the service.

Participants are free to choose between all types of residential services. Individuals indicate on the care plan that they are in agreement with the services and have made an independent choice of provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service includes 24-hour on-site response staff. Medication administration is allowed at the least costly means permitted by State Law. Non-medical transportation (NMT) may be provided as a component of this service and is included in the rate. NMT is allowable as a service combination with ARS when NMT is not a component of the ARS rate. Payment for residential services are not made for room and board, items of comfort or convenience, or the costs of building maintenance, upkeep and improvement. The agency must provide services to at least five adults; provide personal cares, therapeutic, social, and recreational programming.

Residential settings that serve less than five individuals are defined in N.D.C.C. 50-11 as Adult Foster Care (AFC) homes and do not apply to adult residential setttings. The needs of individuals residing in AFC homes are governed under the licensing requirements in N.D.C.C. 50-11 and N.D.A.C. 75-03-21.

To avoid duplication homemaker, chore, emergency response system, adult day care, adult foster care, respite, transitional care, extended personal care, environmental modification, home delivered meals, family personal care, residential habilitation, community support, and companionship services are not allowable service combinations for individuals receiving adult residential services.

To avoid duplication of services, this service cannot be authorized for the same provider who is authorized to provide HCBS Care Coordination services. Adult Residential Services include identifying the individual experience or skills related to the service. This review is supplemental and more in-depth than the person-centered planning core standardized assessment. These coordination activities do not duplicate HCBS Care Coordination. To ensure clear delineation of services and prevent overlapping or duplication, the same provider cannot bill for HCBS Care Coordination and also provide Adult Residential Services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Residential Care

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

N.D.A.C. 33-03-24.1

Certificate *(specify):*

Other Standard *(specify):*

Agency - Licensed as a Basic Care facility with experience providing services to individuals with a diagnosis of either dementia or brain injury. Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07 and have programming to meet recipients needs.

Adult Residential providers are required to submit an assurance that they will report medication errors or omissions per policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment and/or upon notification of provider change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Care Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The HCBS Care Coordination tasks defined in the service of Case Management provide additional support to waiver eligible individuals by promoting health equity, health literacy and cultural humility in person-centered planning. HCBS Care Coordination includes assisting waiver eligible individuals to explore and understand options, make informed choices, solve problems, provide a link between the eligible individual and community resources. Additionally, HCBS Care Coordination provides support and coordination of services to meet the needs of eligible waiver participants through collaboration with Tribal organizations, and culturally based or community-based organizations.

HCBS Care Coordination services are necessary to establish or stabilize waiver eligible participants living in their individual or family home or a community-based setting.

Waiver participants are eligible for HCBS Care Coordination services when a participant is at risk due to health, unstable living situation, or the participant is at risk of institutionalization, such as the following:

Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.).

•Frequent turnover of caregivers and or services resulting in an inability to maintain continuity of care.

•Risk of eviction or loss of current living arrangement.

HCBS Care Coordination services are provided in a manner that protect and supports the participant's health and welfare and is appropriate to the participant's physical and cognitive needs by improving access to services or advancing health equity and health literacy.

HCBS Care Coordination services includes:
•Identifying needs and locating necessary resources to establish or maintain a stable and safe living arrangement.
•Coordinating, educating, and linking the client to resources which will establish or stabilize community supports, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation options, household budgeting, and other needs identified in care plan.
•Providing and establishing networks of relevant participant partners: nursing or institutional facility staff, case managers, community providers (including QSP's), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports, and other involved parties.
•Ensuring all necessary paperwork and documentation is completed to establish or maintain a stable and safe living arrangement.
•Assisting with the development of a plan for, and when necessary, providing emergency assistance to sustain a safe and healthy community setting.
•Assisting the participant in arranging for transportation to effectively connect the participant with the community.

A visit by virtual means can be conducted when individual cannot have an in-person face to face due to extenuating circumstances. The individual may be afforded the option to use the phone or other telehealth technology to engage in the development and/or monitoring of person-centered plans when there are extenuating circumstances impeding the ability to conduct the visit in person. Extenuating circumstances may include instances where the in-person visit poses a health or safety risk to the individual or case manager; public emergency as determined by local, state and federal government.
The participant's services may not be delivered via virtual support 100% of the time. The participant must always have the option to request in-person services. Instances of visit by virtual mean must be approved by the HCBS CM Supervisor or HCBS Program Administration as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion. Any issues will be addressed prior to the implementation of remote supports and documented in the individual's case record.
In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant's dignity and privacy is not permitted. Provider must use a HIPAA compliant service delivery method (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider. Virtual supports are not a system to provide surveillance or for staff convenience.

State employed case managers will be responsible for ongoing monitoring of the provision of services in the services plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limit the provision of HCBS Care Coordination to agency providers.
Provider qualifications to allow culturally or community-based organizations, including non-profit and LLCs and Tribal entities to provide the service.

To avoid duplication of services, HCBS Care Coordination service cannot be authorized for the for the same provider who is authorized to provide the services of Adult Residential Services, Residential Habilitation, Community Support, Transition Coordination, and Transitional Living, as Care Coordination is already an allowable task under these services.

Waiver case management that includes the task of HCBS care coordination may not claim for the service provided to individuals working towards transition until the individual enters the waiver program.

The state will administratively claim for case management services for individuals working towards transition when the until the individual enters the waiver program when both administrative CM and care coordination will be delivered.

State employed case managers will be responsible for ongoing monitoring of the provision of services in the services plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: HCBS Care Coordination

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Community-based, non-profit and LLC organizations in provide services by and for people with disabilities or entities such as Centers for Independent Living, Community Health Representatives, Community Health Worker, Older Americans Act, Older Americans Act Title VI service providers, Tribal organizations, or other culturally based organizations.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Community-based, non-profit and LLC organizations which provide services by and for people with disabilities or entities such as Centers for Independent Living, Community Health Representatives, Community Health Worker, Older Americans Act, Older Americans Act Title VI service providers, Tribal organizations, or other culturally based organizations.
Agency employed HCBS Care Coordinators must have;
•An associate degree or higher in Psychology, Social Work, Social Services, Human Services, Behavioral Sciences, or other closely related field including a medical field, and one year of with a minimum of one year experience providing services with one years' experience in the coordination of community services and supports, e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.
• Qualifying education and experience may be considered in lieu of degree requirement. Qualifying education and experience means;
-two years' experience in the coordination or provision of community services and supports in a social service setting under qualified supervision.
-or four years personal experience with a disability and has documented experience in the coordination of community services and supports in a social service setting.

Training Requirements
Completion of Person-Centered Planning training
Initial and annual HCBS Training on Home and Community Based Services
HCBS Settings Regulation

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment and/or upon notification of provider change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The purpose of homemaker service is to complete intermittent or occasional environmental tasks that an elderly or disabled individual is not able to complete in order to maintain that individuals home such as housework, meal preparation, laundry, shopping, communication, and managing money.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Homemaker service is offered to individuals living alone or living with an individual that is not legally obligated to perform the homemaking tasks. Homemaker services cannot be provided in a provider owned setting.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. If a participant has a need for cleaning of an unusual nature chore services would be authorized. This cap may be increased as determined by legislative action. The case manager makes participants aware of the service cap.

To avoid duplication, homemaker cannot be provided to individuals receiving adult residential services, adult foster care, residential habilitation or community support services.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual & Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals - demonstrating competency in homemaker standards -Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agencies - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment and/or upon notification of provider change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential Habilitation is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

The participant must be able to benefit from skills training, restoration or maintenance and could also benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation.

Residential habilitation will include skills training in order to assist individuals to independently complete tasks such as personal cares, housework, etc. An example may be menu development and creating a grocery shopping list in order to prepare a meal. Another example could be working on the individual steps in order to do laundry.

A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty consecutive calendar days per year per participant, or multiple episodes throughout the year not to exceed 30 total days.

Residential Habilitation provides all-inclusive service provided up to 24 hours a day to individuals who otherwise would be in an institutional setting.

Personal care/assistance or other similar services may be a component part of residential habilitation services but may not

comprise the entirety of the service.

Prior approval is required from an HCBS Program Administrator.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Residential Habilitation may not be authorized with Respite Care, Homemaker, Adult Foster Care, Family Home Care, Personal Care, Family Personal Care, Adult Residential, Transitional Living, Attendant Care, Supervision, Companionship, Community Support Services and Non-Medical Transportation.
• This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
• Supervision may not be authorized in excess of what is necessary for health and safety
• Twenty-four hour supervision in a shared living environment - Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the client or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.
• This service does not include payment for non-medical transportation costs.
• Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.
• Access of services or goods outside of the local area if the same service and goods are available in their local community.
• Travel and direct support outside of the client's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.
• Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.
• Community support services may not be authorized.

Relatives employed by Residential Habilitation Providers cannot be legal spouse and cannot live with the care recipient.

To avoid duplication of services, this service cannot be authorized for the same provider who is authorized to provide HCBS Care Coordination services. Residential Habilitation services include identifying the individual experience or skills related to the service. This review is supplemental and more in-depth than the person-centered planning core standardized assessment. These coordination activities do not duplicate HCBS Care Coordination. To ensure clear delineation of services and prevent overlapping or duplication, the same provider cannot bill for HCBS Care Coordination and also provide Residential Habilitation.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Agency QSPs enrolled under NDAC 75-03-23 may include Agency Adult Foster Care Facilities licensed according to proposed NDAC 75-03-21.1 and DD Providers Licensed for Residential Habilitation licensed according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify):*

Providers must ensure that staff are adequately trained and qualified as evidenced by:
1) Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills;
2) Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01;
3) Department approved training on TBI and dementia;
4) In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment and/or upon notification of provider change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite Care is for the purpose of providing temporary relief to the individuals primary care provider from the stresses and demands associated with constant care or in emergencies. Federal Financial Participation (FFP) may not be claimed for room and board when respite is provided in the participant's home or place of residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The primary caregiver's need for relief is intermittent or occasional; the client requires a qualified caregiver during the primary caregiver's absence; and/or the relief is not for the primary caregiver's employment or to attend school. Respite care can be provided in the client's residence, adult foster care home, hospital, nursing facility, swing bed facility, or in the private home of approved respite home care provider.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. The cap allows for approximately 9 hours of in-home respite care per week at the maximum provider rate allowed or 4 days of institutional respite care per month. If multiple clients live in the same home and have the same primary caregiver the respite cap must be divided by the number of client's in the home however, additional dollars may be added to the allocation for each additional client served. Additional respite dollars may be allocated because primary caregivers who are providing care to more than one client at a time are more likely to need additional respite care because of increased caregiver burden. The per day cost of institutional or in-home respite care cannot exceed the swing bed rate. These caps may be increased as determined by legislative action.

The Department of Health and Human Services may grant approval to exceed the service cap if the client has special or unique circumstances; the need for additional services does not exceed 3 months; and the total need for service does not exceed the individualized budget amount. Under emergency circumstances, the Department may grant a one-time extension not to exceed an additional three months. The case manager makes participants aware of the service cap.

Respite is allowed for a maximum of 14 consecutive days when the service is provided continuously.

To avoid duplication, respite care cannot be provided to individuals receiving adult residential services, residential habilitation, or community support services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Agency only - N.D.C.C. 23-16, N.D.A.C. 33-07-01, 33-07-03.2 N.D.A.C. 33-03-24.1

Certificate *(specify):*

Other Standard *(specify):*

Individual - Demonstrating competency in respite care standards - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Basic Care, Swing Bed, and Nursing Facilities that provide respite care are required to submit an assurance that they will report medication errors or omissions per policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment and/or upon notification of provider change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported employment includes activities needed to sustain paid work including supervision and training for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need the provision of intensive, ongoing support to perform in a work setting with necessary adaptations, supervision, and training appropriate to the persons disability.

Supported employment recipients must work in a competitive work setting i.e. hotels, restaurants, retail establishments, offices, home based self-employment etc. All individuals currently utilizing this service are working in competitive work settings. This service includes individualized training and is not conducted in a group setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Supported employment cannot be provided in any setting that would isolate recipients from the community i.e. sheltered workshops etc. Services may not be provided in group settings.

Activities would not include supervision or training activities provided in a typical business setting nor prevocational skills development. Service tasks will only be authorized for the adaptations, supervision, and training required by the client as a result of their disability. Transportation will be provided as an aspect of this program and the cost is included in the rate paid to providers of this service.

Documentation is maintained in the file of each participant that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) and that they have completed the supported employment program available through Vocational Rehabilitation. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

CARF or N.D.A.C. 75-04-01

Certificate *(specify):*

Other Standard *(specify):*

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment and/or upon notification of agency status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Waiver Personal Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The purpose of Waiver Personal Care (WPC) is to provide a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Such assistance may include assistance in performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, e.g. light housework, laundry, meal preparation, grocery shopping, using the telephone, medication and money management). Such assistance also may include the supervision of participants as provided in the service plan. Supervision means having the knowledge of, and account for, the activity and whereabouts of the recipient at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. Supervision includes the provider being immediately available to furnish assistance and direction throughout the performance of and/or at the ready to perform the next personal care task (i.e. bathing, toileting, transferring, locomotion etc.) that is necessary to meet the intermittent personal care need of the participant.

Waiver Personal Care is furnished both inside and outside the participant's home. WPC may be provided outside the participants home when the participant is needing personal cares while outside of their home.

Personal care may be furnished in order to assist a person to function in the workplace or as an adjunct to the provision of employment services.

Personal care services may be provided on an episodic or on a continuing basis.

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the state plan. Waiver Personal Care differs in scope and nature from the personal care offered under the State Plan as supervision may be provided. A participant cannot be authorized to receive both services at the same time.

When WPC is provided by a non-agency provider, participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the case manager performs monitoring of a participant's person-centered plan with the participant. This monitoring includes monitoring of the use or non-use of waiver services. At a minimum, this monitoring occurs on a quarterly basis.

Personal care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

To avoid duplication, waiver personal care recipients are not eligible for adult residential care, adult foster care, residential habilitation, and community support services.

As permitted by state law, meal preparation is limited to the maximum units set by the department.

Homemaker (Laundry, shopping, and housekeeping) tasks when provided as personal care service limited to the maximum

units set by the department, and the cap cannot be exceeded under other waiver services.

The state assures WPC being provided to the participant are not duplicative of extended personal care as WPC does not include hands-on care of a medical nature that is specific to the needs of an eligible individual that is provided under extended personal care. The state ensures non-duplication with extended personal care through thorough assessment and monitoring of participant services through person centered planning.

Live-in relatives meeting the definition of family member under subsection 2 of N.D.A.C 50-06.2-02 are not eligible to provide Waiver Personal Care service. Live in relatives must provide the service through Family Personal Care. This includes live-in family members who are hired or seeking to be hired under an agency provider.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

All providers of waiver services must be enrolled Qualified Service Provider N.D.A.C. 75-03.23-07

Certificate *(specify):*

Other Standard *(specify):*

All providers of waiver services must be enrolled Qualified Service Provider N.D.A.C. 75-03.23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Department of Health and Human Services

Frequency of Verification:

Initial/re-enrollment and/or upon notification of provider change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Foster Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistance with ADL's, IADLs and supportive services provided in a licensed private home by a care provider that lives in the home. Adult foster care is provided to adults who receive these services while residing in a licensed home. The total number of individuals who live in the home who are unrelated to the care provider cannot exceed four.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service must be provided in a licensed Adult Foster Care (AFC) home. Services are provided to the extent permitted under state law. To avoid duplication homemaker, chore, emergency response system, residential care, transitional care, home delivered meals, family personal care, environmental modification, supervision, non-medical transportation, residential habilitation, community support and companionship services are not allowable service combinations for individuals receiving AFC. Non-medical transportation is a component of AFC and is included in the rate.

The cost of this service is limited to a maximum monthly cap set by the Department. If the client's needs cannot be met within the allowed rate case management would explore other waiver service options with the participant. The case manager makes participants aware of the service cap.

Adult foster care is provided to adults while residing in a licensed home. The total number of individuals who live in the home who are unrelated to the care provider cannot exceed four.

The service of Adult Foster care will not be provided in an Agency Adult Foster Care Setting. Adult Foster Care Service will only be provided in individual Adult Foster care homes.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Adult Foster Care (AFC) licenses - N.D.C.C. 50-11; N.D.A.C. 75-03-21

Certificate *(specify):*

Other Standard *(specify):*

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Aging Services Division (background check verification & licensing) & Medical Services Division (provider enrollment)

Frequency of Verification:

Initial licensing of an AFC home is valid for 1 year. AFC homes are re-licensed every 2 years after the 1-year initial licensing period.

Re-enrollment of QSP status and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Chore Service is provided to complete tasks, which an elderly or disabled individual is not able to complete in order to remain independent in his/her own home. Tasks include activities such as cleaning of an unusual nature, moving heavy furniture, floor care of unusual nature, cleaning of appliances, snow removal, lawn mowing, professional extermination or sanitation. The tasks authorized must be directly related to the health and safety of the client.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Chore services cannot duplicate the services provided under homemaker. Chore tasks may include but are not limited to pest control, snow removal, lawn mowing, heavy spring cleaning etc. They are provided on a one-time or intermittent bases and must be provided in the client's home. Chore service is not authorized if the tasks are the responsibility of the landlord. These services will be provided only in cases where the client or any other adult in the household is not capable of performing the activity.

The State also monitors this service through case management audits that are conducted annually.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Agency & Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Individual

Provider Type:

Agency & Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual - Demonstrating competency in chore standards - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Support Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community supports is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Community Supports may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

The participant must be able to benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation.

Community Support Services will not include a training component as the individuals utilizing this service are not physically able to do the tasks. For example, the recipient knows the steps in order to do laundry but isn't physically capable of completing the task.

A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty consecutive calendar days per year per participant, or multiple episodes throughout the year not to exceed 30 total days.

Community Support Services provides all-inclusive service provided up to 24 hours a day to individuals who otherwise would be in an institutional setting.

Prior approval is required from an HCBS Program Administrator.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Support Services may not be authorized with Respite Care, Homemaker, Adult Foster Care, Family Home Care, Personal Care, Family Personal Care, Adult Residential, Transitional Living, Attendant Care, Supervision, Companionship, Residential Habilitation and Non-Medical Transportation.
• This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.

• Supervision may not be authorized in excess of what is necessary for health and safety
• Twenty-four hour supervision in a shared living environment - Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the client or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.
• This service does not include payment for non-medical transportation costs.
• Payment for Community Support Services does not include room and board, or the cost of facility maintenance and upkeep.
• Access of services or goods outside of the local area if the same service and goods are available in their local community.
• Travel and direct support outside of the client's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.
• Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.
• Residential habilitation may not be authorized.

Relatives employed by Community Support Providers cannot be legal spouse and cannot live with the care recipient.

To avoid duplication of services, this service cannot be authorized for the same provider who is authorized to provide HCBS Care Coordination services. Community Support waiver services include identifying the individual experience or skills related to the service. This review is supplemental and more in-depth than the person-centered planning core standardized assessment. These coordination activities do not duplicate HCBS Care Coordination. To ensure clear delineation of services and prevent overlapping or duplication, the same provider cannot bill for HCBS Care Coordination and also provide Community Support.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support Service

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Agency QSPs enrolled under NDAC 75-03-23 may include Agency Adult Foster Care Facilities licensed according to proposed NDAC 75-03-21.1 and DD Providers Licensed for Residential Habilitation licensed according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify):*

Provider must ensure that staff are adequately trained and qualified as evidenced by:
1) Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills;
2) Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01;
3) Department approved training on TBI and dementia;
4) In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The purpose of Community Transition Services is to assist eligible individuals transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the client is directly responsible for his or her own living expenses and needs non-recurring set-up expenses. Community transition services include one-time set-up expenses and transition coordination. Transition coordination assists an individual to procure one-time moving costs and/or arrange for all non-Medicaid services necessary to assist the individual with the actual coordination and implementation of their individualized plan to move back to the community. The non-Medicaid services may include: assisting with finding housing to include searching, coordinating deposits, and/or utility set-up; helping participants set up their households by identifying needs, help with shopping, and/or selection of household goods; arrange the actual move by getting things out of storage, and/or finding movers; identifying the community in which the participants wants to live; identifying and coordinating transportation options for the move; and assisting with community orientation to locate and learn how to access community resources.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Transition Services do not include expenses that constitute room and board; monthly rental or mortgage expense; escrow; specials; insurance; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person and 90 days from the date the client became eligible for the waiver. Transition coordination is limited to 300 hours. One-time set-up expenses are limited to $3000 per eligible individual. Community Transition Services requires prior approval from the HCBC Program Administrator to prevent any duplication of services. When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.

To avoid duplication of services, this service cannot be authorized for the same provider who is authorized to provide HCBS Care Coordination services. Transition Coordination waiver services include identifying the individual experience or skills related to the service. This review is supplemental and more in-depth than the person-centered planning core standardized assessment. These coordination activities do not duplicate HCBS Care Coordination. To ensure clear delineation of services and prevent overlapping or duplication, the same provider cannot bill for HCBS Care Coordination and also provide Transition Coordination.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Agency staff: Completion of an associate or bachelor's degree in sociology, social services, social work, nursing, or a field related to programmatic needs from an accredited university. Staff with an associate degree must also have at least one year of progressively responsible experience in programs related to the task.
Individual providers: Completion of a bachelor's degree in sociology, social services, social work, nursing, or a field related to programmatic needs from an accredited university.

Certificate *(specify):*

Other Standard *(specify):*

Individual - Enrolled Medicaid Provider and Enrolled Qualified Service Provider (QSP) NDAC 75-03-23-07
Agency - Enrolled Medicaid Provider and Enrolled QSP NDAC 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companionship Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ● **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-medical care, supervision and socialization, provided to a waiver recipient who lives alone in a private dwelling or family member's private dwelling or with an individual who is not capable or obligated to provide the service. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping but do not replace homemaker tasks. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service must be provided in accordance with a therapeutic goal in the service plan.

Reduce social isolation in older adults and individuals with physical disabilities who are eligible for the home and community based services waiver and live alone or with an individual who is not capable or obligated to provide care. Companionship services reduce social isolation which can have a negative impact to physical and mental health that can lead to institutional placement.

Socialization that is therapeutic is directly tied to the individual's goal(s) in the person centered plan.

Activities that support therapeutic socialization could also be associated with a care plan goal to reduce social isolation, or help the individual maintain the most inclusive community life.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Companionship services do not include hands-on nursing care, and activity fees (e.g. movie or event fees) but may include verbal instruction or cuing;

Services can only be provided to clients who live alone or with someone who is not able or is not obligated to provide the care;

Companionship cannot be combined with adult foster care, adult residential care, family personal care, family home care, non-medical transportation w/escort, personal care, transitional living, residential habilitation, community support services, and recipients of the senior companion program under the Cooperation for National and Community Service;

Companionship services cannot be provided by an individual who is identified as the recipients relative within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companionship Service

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Enrolled as a Qualified Service Provider (QSP) NDAC 75-03-23-07

Certificate *(specify):*

Other Standard *(specify):*

Individuals enrolled as a QSP who meet the standards to provide adult companion services except for individuals who are identified as a relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.

Employees of agencies enrolled to provide this service cannot use an employee who is identified as a relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.

All individual companionship providers and the employees of agency providers must also have the global endorsement for cognitive/supervision.

Agencies may enroll as a QSP that meet the standards for adult companion services must;
• be enrolled to provide companion service under the Corporation for National and Community Service Senior Companion Programs and meet all the standards established by the Corporation for National and Community Service National and Community Service Senior Companion program grantees and provide verification of organization credentials is done by the national corporation.
• Employees of organizations enrolled to provide this service cannot use an employee who is identified as a relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.
• Organization employees/volunteers do not require the cognitive/supervision endorsement.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Emergency Response

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The purpose of Emergency Response Systems is to allow individuals to access emergency call systems during the absence of human assistance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to persons cognitively and physically capable of activating the emergency call. This service is not available to individuals who live with someone unless the individual is incapacitated or their periodic absence presents a safety risk.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergency Response

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental modification is physical adaptations to the home required by the individuals' plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence, and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and are necessary for the welfare of the recipient.

Environmental Modification, vehicle modifications is adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate mor fully into the community and ensure the health, welfare and safety of the participant. The following are specifically excluded: 1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual; 2. purchase or lease of a vehicle; and 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Funds for this service may be used to meet the excess disability related expenses that is not covered through the Medicaid State Plan to maintain a recipient living in their own home or the home of their family member. The home must be owned by the recipient or the recipient's family member or rented by an eligible waiver recipient.

A written recommendation by an appropriate professional is required to ensure that the home/vehicle modification will meet the needs of the recipient if the estimated cost of the modification is more than $500. The cost of the assessment to provide a written recommendation is an allowable expense if the cost of the assessment is not covered under the State Plan. The cost of the evaluation must be included in the cost estimate submitted to the Department and the total cost of the modification and the assessment cannot exceed the current funding cap without prior approval from program administration.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Modifications may be made to a home owned or rented by a recipient or the home of the recipient's family member if the recipient resides in that home. Modifications will enable the recipient to provide self-care or receive care and allows the recipient to safely stay in the home for a period of time that is long enough to offset the cost of the modification. Modifications are not for routine home maintenance, (such as carpeting and/or floor repair, plumbing repair, roof repair, central air conditioning, appliance repair, electrical repair, etc.) but are to promote independence. Adaptations, which add to the total square footage of the home, are not allowed. All services shall be provided in accordance with applicable state and local building codes.

The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact. Payment may not be made to adapt vehicles that are owned or leased by non- family paid providers of waiver services.

For environmental modification the dollar limit cannot exceed the current highest monthly rate for the highest cost skilled nursing facility. Exceptions to this service cap may be approved by program administration. The cost of the evaluation must be included in the cost estimate submitted to the Department and the total cost of the modification and the assessment cannot exceed the current funding cap. If the recipient's needs cannot be met within the allowed rate case management would explore other service options with the participant and may request a reasonable modification from program administration to

exceed the cap. The case manager makes participants aware of the service cap.

All medically necessary services for children including environmental modification are covered under Early Periodic Screening Diagnosis and Testing (EPSDT).

The services under Environmental Modifications are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization."

Pre-approval from the Department of Health and Human Services is required before this service can be authorized.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Contractors, Tradesmen, Electricians or Plumbers - N.D.C.C. 43-07, 43-09, N.D.C.C. 43-18

Certificate *(specify):*

Other Standard *(specify):*

Tradesmen Qualification Requirements
Individual - Bonded, Licensed, Enrolled with Secretary of State, and in good standing with Workforce Safety - General Contractor, Plumber, Electrician - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Bonded, Licensed, Enrolled with Secretary of State, and in good standing with Workforce Safety - General Contractor, Plumber, Electrician - Enrolled QSP N.D.A.C. 75-03-23-07

Unlicensed contractor (Handyman) in good standing with Workforce Safety - who has provided appropriate professional references relevant to their ability to complete the necessary work. Can provide services not to exceed four thousand dollars in time and materials. N.D.C.C. 43-07-02

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Extended Personal Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11010 health monitoring
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**
05 Nursing	05020 skilled nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Extended personal care includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service may include skilled or nursing care to the extent permitted by State law.

Extended Personal Care is provided to the individual waiver participant.

A nurse, licensed to practice in the state, will be reimbursed to provide training to the individual waiver participant and individual approved by the Department who will be reimbursed to perform the required care. Or, if a necessary medical task is too complex to be taught to an unlicensed provider the nurse may be paid to provide the service directly to the client. The nurse educator will provide at a minimum, a review of the client's needs every six months to determine if additional training and or tasks are required. Activities of daily living and instrumental activities of daily living are not a part of this service. The training is participant specific and is not general and required to be a provider of the service, the provider's participation in this waiver participant-training can be claimed under the waiver service that they are delivering. In that instance, the individual/agency providing the training should not be claimed under this same service.

The licensed nurse is required to participate in the development of a plan of care for individuals who require assistance with maintenance of routine nursing tasks. Other requirements include following established protocol for reporting incidents to the Department of Health and Human Services.

Extended Personal Care may be provided in the form of Medical Care Coordination which includes escorting the waiver participant to medical appointments and providing support to the individual in coordinating medical services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Activities of daily living and instrumental activities of daily living are not a part of this service. The need for extended personal care is limited to individuals who have cognitive or physical impairments that prevent them from performing these activities. Individuals who have cognitive impairments and are not able to participate in the training process are required to have a legally responsible person present during the training.

Nurse education service may be provided remotely through virtual supports as determined necessary to ensure services are delivered while considering participant choice, compliance with CMS requirements and identified in the participant's person-centered plan. If the participant requires hands on assistance for a specific task, then virtual supports service delivery cannot be an option for that task but may be utilized for other tasks that do not need hands on support.

A Virtual Support Checklist will be required to be completed by the Nurse Educator and the team during the person-centered planning process. This checklist will act as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion. Any issues will be addressed prior to the implementation of remote supports. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery. The Virtual Support Checklist will include consideration of the estimated hours/visits that virtual supports delivery will be utilized. The risk assessment and service plan require the team to develop a plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided.

In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant's dignity and privacy is not permitted. Virtual supports reinforce community integration by encouraging the participant to engage in community life as independently as possible and to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities.

The participant's services may not be delivered via virtual support 100% of the time. The participant must always have the option to request in-person services. The amount of time chosen shall be determined during the person-centered planning process and outlined in the Individual Service Plan. Provider must use a HIPAA compliant service delivery method (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider. Virtual supports are not a system to provide surveillance or for staff convenience.

Pre-approval from the Department of Health and Human Services is required before this service can be authorized. To avoid duplication, individuals who are receiving extended personal care are not eligible for family personal care and adult residential services.

Extended Personal Care is provided only when the services are not available through the Medicaid State Plan, Early Periodic Screening Diagnosis and Testing (EPSDT), under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or available through a third-party resource.

Home Health is different from extended personal care because it is delivered through a home health agency and provided by a nurse that is providing skilled care for an acute condition. Extended personal Care Services are services delivered by a Qualified Service Provider that has been specifically trained by a nurse educator to perform the delegated task. One example of EPCS would be administering medications to a medically stable client or dressing changes for a wound that is healing.

The training is specific to the client and information must be sent to the Department clarifying that the training was done to the QSP and the QSP successfully carried out the task. The case manager assures the services being provided to the client are not duplicative of home health services while visiting the client and doing a thorough assessment.

Any transportation costs that are not associated with the provision of personal care are not personal care services and thus, would have to be billed separately and may not be included in the scope of this service. Instead, the service provider may furnish and bill separately for transportation provided that they meet the state's provider qualifications for transportation, whether non-emergent medical transportation under the state plan (for transportation to medical appointments) or non-medical transportation under the waiver.

Personal care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Extended Personal Care

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Nurse Educator:

Individual - N.D.C.C. 43-12.1: N.D.A.C. (54-02, 54-05)

Agency - N.D.C.C. 43-12.1; N.D.A.C. (54-02, 54-05)

An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board of nursing; submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought; pass an examination approved by the board of nursing.

An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board; submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought; submit proof of initial licensure by examination with

the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure; submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

Certificate *(specify):*

Other Standard *(specify):*

Individual- Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions per policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Personal Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Family personal care assists individuals to remain with their family members and in their own communities by allowing individuals who want to choose their spouse or one of the following family members as defined under subsection 2 of the N.D.C.C. 50.06.2-02;: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew, as their family personal care service provider.

Payment will only be made to legal spouses or family members who reside in the same home. Individuals who choose a provider who is not their legal spouse or family as defined under N.D.C.C. 50.06.2-02 will be served under Medicaid State plan personal care.

Personal care or similar services includes, assistance with the ADLs/ IADLs of bathing/ hygiene, dressing, incontinence care, toileting, transferring/positioning, mobility and feeding/eating. It also includes assistance with the tasks of eye care, medication assistance, cognitive supervision, exercise, hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthetic orthotics, suppository/ bowel program, ted socks, vital signs, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage and specialty bed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment will only be made to legal spouses or family members who reside in the same home. Individuals who choose a provider who is not their legal spouse or family as defined under N.D.C.C. 50.06.2-02 will be served under Medicaid State plan personal care.

Payment will not be made for assistance with the tasks of communication, community integration, housework, laundry, meal preparation, money management, shopping, social appropriateness, and transportation.

This service cannot duplicate personal care that must be provided as part of an Individual Education Plan (IEP) as required by the Individual with Disabilities Education Act while a recipient is attending school. Case managers are required to assure that other third party funding sources do not duplicate waivered services.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. This cap may be increased as determined by legislative action.

To avoid duplication, family personal care recipients are not eligible for adult residential care, adult foster care, transitional living, residential habilitation, community support and companionship services.

Live in relatives meeting the definition of family member under subsection _ of N.D.A.C 50-06.2-02 can provide Family Personal Care services. This includes live-in family members who are hired or seeking to be hired under an agency.

Family Personal Care is not available to individuals who are eligible to receive such services through the Medicaid State Plan or Early Periodic Screening Diagnosis and Testing (EPSDT).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Personal Care

Provider Category:

Individual

Provider Type:

Individuals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals- demonstrating competency in family personal care standards -Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

06 Home Delivered Meals	06010 home delivered meals

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The provision of nutritious and well-balanced meals to individuals who live alone and are unable to prepare an adequate meal for themselves or who live with an individual who is unable or not available to prepare and adequate meal.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
At a minimum, each meal must meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Americans.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 2 hot, frozen and/or refrigerated, ready to eat meals per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individual or Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Individual or Agency

Provider Qualifications

License *(specify):*

Licensed, as a ND food establishment per N.D.C.C. 23-09 - Does not pertain to hospitals, nursing homes, basic care facilities, and OAA nutrition providers, or facilities that prepare and ship meals nationally which must be licensed and regulated by the U.S. Department of Agriculture.

Hospitals - N.D.C.C. 23-16 & N.D.A.C. 33-07-01.1 (Dietary Service Standards)& N.D.A.C. 33-07-02.1 (General Construction/Equipment Standards)

Nursing Facilities - N.D.C.C. 23-16 & N.D.A.C. 33-07-03.2 (Dietary Service Standards) & N.D.A.C. 33-07-04.2 (General Construction Equipment Standards)

Basic Care - N.D.C.C. 23-09.3 & N.D.A.C. 33-03-24.1 (Dietary Service Standards)

Certificate *(specify):*

Other Standard *(specify):*

Individual - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

OAA Nutrition Providers are required to comply with all requirements contained in the State and Community Programs funded under the Older Americans Act Service Chapter 650-25-45 Nutrition Program Standard.

Hospitals certified to participate in the Medicare and Medicaid Program are required to meet federal dietary service standards under 42 CFR 482.28. Nursing facilities certified to participate in the Medicare and Medicaid Program are required to meet federal dietary service standards per 42 CFR 483.35.

In addition, all providers are required to meet all applicable federal, state, and local laws and regulations regarding the safe and sanitary handling of food, equipment, supplies, and materials used in storage, preparation, and delivery of meals to eligible recipients pursuant to the North Dakota Requirements for Food and Beverage Establishments (N.D.A.C. 33-33-04).

Verification of Provider Qualifications

Entity Responsible for Verification:

The licensing and inspection of ND food establishments is the responsibility of the State Health Department or local health jurisdiction. The licensing and inspection of facilities that prepare and ship meals nationally is the responsibility of the U.S. Department of Agriculture.

The licensing and surveying of hospitals, nursing homes and basic care facilities is the responsibility of the ND Department of Health and Human Services.

Aging Services Division is responsible to conduct meal site assessments of OAA nutrition providers to assure compliance with OAA standards.

The Department of Health and Human Services Medical Services Division HCBS is responsible for enrolling home delivered meal providers as Qualified Service Providers (QSP).

Frequency of Verification:

QSPs must provide verification at initial enrolment or re-enrollment which is required every two years, and /or upon notification of a provider status change. ND licensed food establishments that request to enroll as a QSP to provide home delivered meals are also required to submit a 4 week cycle menu which will be reviewed by a licensed dietician or nutritionist pursuant to N.D.A.C. 43-44. The menus are reviewed to assure they meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Americans.

OAA nutrition providers, hospitals, nursing homes and basic care facilities are not required to submit sample menus because their menus are reviewed when they contract with Aging Services Division or are licensed by the Department of Health. Facilities regulated by the Department of Agriculture must submit proof that their meals meet the USDA's Dietary

Guidelines for Americans.

Non-accredited hospitals are surveyed at initial licensing and certification and recertified by on-site survey approximately every 4-5 years. In addition, hospitals are licensed or re-licensed annually without an on-site survey.

Nursing Facilities initial certification and recertification plus re-licensure is conducted by an annual survey.

Basic Care Facilities the frequency of survey is not mandated. These facilities are re licensed annually but the on-site survey is completed on the average of 3-4 years as funding allows.

ND Licensed Food Establishments undergo a preoperational inspection. The Department of Health and Human Services conducts more frequent inspections based upon its assessment of a food establishment's history of compliance with the N.D.A.C. 33-33-04 Food Code and the establishment's potential as a vector of food borne illness.

USDA facilities undergo an initial inspection and regulated facilities are visited at a frequency that is appropriate to ensure that selected establishments are operating in a manner that is consistent with the Federal Meat Inspection Act, Poultry Products Inspection Act, and or Egg Products Inspection Act.

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

To enable waiver participants to gain access to waiver and other essential community services or resources as specified by the service plan to maintain the participant in their home and community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

With the exception of NMT to access waiver services, service tasks would not include transporting clients to/from work or school nor to facilitate socialization, to participate in recreational activities, or to medical appointments. This service is not available when transportation is provided as a component part of another service including transportation provided under an Individual Education Plan (IEP) as required by the Individual with Disabilities Education Act. Case Managers are required to assure that other third party funding sources do not duplicate waiver services. State office staff review individual care plans to assure that the combination of services does not allow duplication of non-medical transportation.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Individual - N.D.C.C. 39-06

Agency - N.D.C.C. 39-06

Certificate *(specify):*

Other Standard *(specify):*

Individuals- must have valid drivers license, road worthy vehicle, clear driving records, and proof of insurance. Be enrolled as a Qualified Service Provider(QSP) per N.D.A.C. 75-03-23-07. If a provider will be using another individual's vehicle to provide this service the owner of that vehicle must provide proof of insurance and a written statement that they have given

the provider permission to use the vehicle for this purpose.

Agency -Enrolled QSP per N.D.A.C. 75-03-23-07. If an agency employee will be using another individual's vehicle to provide this service the owner of that vehicle must provide the proof of insurance and a written statement that they have given the provider permission to use the vehicle for this purpose.

Agencies may enroll as a QSP to provide this services that meet the standards for adult companion services must;
• be enrolled to provide companion service including transportation under the Corporation for National and Community Service Senior Companion Programs and meet all the standards established by the Corporation for National and Community Service National and Community Service Senior Companion program grantees and provide verification of organization credentials is done by the national corporation.
• Employees of organizations enrolled to provide this service cannot use an employee who is identified as a relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.
• Organization employees/volunteers do not require the cognitive/supervision endorsement.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Equipment & Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized equipment, supplies, safety devices, or assistive technology that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Items reimbursed with waiver funds are only for medical equipment and supplies not covered under the State Plan; and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture and design. Coverage may include the cost of installation, set up, maintenance, and upkeep of equipment, and may also include the cost of training the participant or caregivers in the operation and/or maintenance of the equipment.

Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:
1) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3) Services consisting of selecting, designing, fitting, customizing, adapting, installing, applying, maintaining, repairing, or replacing assistive technology devices;
4) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
5) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

•The goods can only include the purchasing of items that relate directly to the clients care needs.
•Goods requiring structural changes to the home are not allowed through this service.
•Pre-approval from the Department of Human Services is required before this service can be authorized.
•Participants 18-21 will receive this service if deemed medically necessary as EPSDT under the state plan.
•A written recommendation must be obtained by an appropriate professional (OT, PT, SLP, Assistive Technology Professionals (ATP) etc.) to ensure that the equipment will meet the needs of the participant prior to consideration for approval.
•Generic technical devices (tablets, computers, etc.) are only allowed when they are needed for the functionality of other assistive technology such as smart home devices.

The services under Specialized Equipment are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization."

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment & Supplies

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supervision

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02033 in-home round-the-clock services, other

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Up to 24 hours of supervision may be provided to individuals who because of their assessed need require monitoring to assure their continued health and safety.

Supervision means having the knowledge of, and account for, the activity and whereabouts of the recipient at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. During the time that the provider is supervising the recipient they may play games, visit, read, and participate in activities with the client. If the client is physically able, they may also participate in activities in or around the recipient's home such as gardening, or going for short walks etc. Supervision is not authorized for payment of Supervision and Respite Care during the same time.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Supervision can only be authorized during the time that no other services are being provided to the recipient. Providers who provide supervision at night while the client is sleeping, must stay awake while providing supervision.

Supervision can be authorized with the following services, but payment for supervision cannot be claimed, during the time these services are being provided: Homemaker, Respite Care, Extended Personal Care, Chore, Non-Medical Transportation, Medicaid State Plan Personal Care, Transitional Care, Supported Employment, Adult Day Care, Community Transition Services and Companionship Services. Supervision cannot duplicate the services provided under transitional living.

To avoid duplication of services Supervision cannot be combined with: Adult Foster Care, Residential Services, Residential Habilitation, Community Support and Family Personal Care as supervision is already an allowable task under these services. Supervision cannot be combined with an Emergency Response System as this service is not meant to replace the need for human intervention.

Live-in relatives meeting the definition of family member under subsection 2 of N.D.A.C 50-06.2-02 are not eligible to provide supervision service. This service is provided under Family Personal Care. This includes live-in family members who are hired or seeking to be hired under an agency provider.

Supervision does not include taking/transporting recipients out of the home to community/social events etc.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supervision

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual demonstrating competency in supervision standards - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07
Agencies - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Living

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration

Category 2:

04 Day Services

Sub-Category 2:

04020 day habilitation

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Included is supervision, training, or assistance to the recipient with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living and mobility. Staff support including escort services is provided for supervision, independent living skills training until the interdisciplinary team determines this service is no longer appropriate.

Any eligible waiver recipient who needs these types of services can utilize transitional services. Transitional services are not limited to persons with a brain injury.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A program that provides training for the recipient to live with greater independence in his/her home or apartment. Transitional living will be provided under this waiver if it cost-effective and if necessary to avoid institutionalization.

This service is provided only until independent living skills development has been met or until the interdisciplinary team determines this service is no longer appropriate. If the individual is unable to achieve independent living skills and remains eligible for state and federal funded services the care plan is reviewed by the case manager and the individual to transition them from transitional care to a combination of state plan and waiver services such as personal care, homemaker, escort etc.

To avoid duplication, homemaker, adult day care, adult foster care, residential care, family personal care, residential habilitation, community support, and companionship services are not allowable service combinations for individuals receiving transitional living services. Transitional living services cannot be provided at the same time as supervision.

Non-medical transportation to transport the client is allowed. Escort to accompany the individual while they are being transported is not allowed, as it is a component of transitional care services.

To avoid duplication of services, this service cannot be authorized for the same provider who is authorized to provide HCBS Care Coordination services. Transitional Living waiver services include identifying the individual experience or skills related to the service. This review is supplemental and more in-depth than the person-centered planning core standardized assessment. These coordination activities do not duplicate HCBS Care Coordination. To ensure clear delineation of services and prevent overlapping or duplication, the same provider cannot bill for HCBS Care Coordination and also provide Transitional Living.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Living

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Experience providing services to individuals with a diagnosis of brain injury - Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/re-enrollment as required under N.D.A.C. 75-03-23-07

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete*

item C-1-c.

☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☑ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Case Management functions performed by HCBS Case Managers employed by the state are administratively claimed services including; accessing waiver services, the completion of the HCBS comprehensive assessment, level of care screening, person-centered planning, monitoring, reassessment, implementation of the person-centered plan including assisting the eligible individual to explore and understand options, make informed choices, solve problems, provide a link between community resources, and qualified service providers, and closure and termination of services.

Case management service under the waiver is HCBS Care Coordination. HCBS Care Coordination includes assisting waiver eligible individuals to explore and understand options, make informed choices, solve problems, provide a link between the eligible individual and community resources.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

● **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal background checks are only completed for Adult Foster Care (AFC) and respite providers who provide care in an AFC home. Statutory authority to conduct background checks is limited to licensed AFC providers and respite workers who provide care in an AFC home.

AFC Providers are required to submit to both State and Federal background checks unless they have resided in the State continuously for eleven years or since reaching age 18, whichever is less; or if they are on active US military duty or have resided continuously in the State since receiving an honorable discharge.

N.D.C.C. 50-11 provides for nationwide, fingerprint based criminal background checks for AFC providers and their respite workers. The AFC licensure from the Aging Services monitors the need for a background check as part of AFC licensing. Staff from Aging Services Division receive and review the background check requests to assure all required information has been included. The background checks are submitted to the Bureau of Criminal Investigation for completion. Once the background check is complete the reports are returned to Aging Services. If the report indicates an offense the report is reviewed by an attorney from the Legal Service Division to ascertain whether the conviction will have an effect on the ability of that person to provide care in an AFC home as required in N.D.A.C. 75-03-21-09.1.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ● **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For individual service providers the State Medicaid agency checks the - Board of nursing registry of licensed nurses and unlicensed assistive persons (UAP's) and Department of Health and Human Services Certified Nurse Assistant's and nurse aide registry; Attorney General's Sexual Offender's registry, ND State Court website, debarment database; excluded parties list system (EPLS), and the Department of Health and Human Services HCBS provider complaint/termination database.

The state Medicaid agency maintains a provider state exclusion list. The state provider exclusion list includes providers who have had findings of abuse or neglect, fraudulent claims or egregious billing practices. Being on the provider list ensures that the provider cannot work with any entity that receives Medicaid funded programs.

For agency service providers the State Medicaid agency checks the - debarment database; excluded parties list system (EPLS), and the Department of Health and Human Services HCBS provider complaint/termination database. For newly enrolled service providers, the agency is responsible to assure direct service employees have met standards and requirements.

Mandatory screenings are conducted initially and annually through the provider enrollment process. The provider cannot be enrolled or re-renewed without the mandatory checks being complete.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ● **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Legal spouses including (under certain circumstances) spouses who have decision making authority over their spouse may be paid to provide family personal care.

Payment may be made to a legally responsible person if the recipient chooses them as their provider and if the provider meets all of the required qualifications to enroll as a Qualified Service Provider for Family Personal Care or Waiver Personal Care. If the legally responsible person wants to become the provider and has decision making authority over the recipient the case manager must pre-approve the arrangement. The case manager is responsible to note in the participants case note and forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.

Extraordinary care consists of personal care or similar services and includes assistance with the ADL's/IADL's of bathing/ hygiene, dressing, incontinence care, toileting, transferring/positioning, mobility and feeding/eating. It also includes assistance with the tasks of eye care, medication assistance, cognitive supervision, exercise, Hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthetic orthotics, suppository/bowel program, ted socks, vital signs, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage and specialty bed. Payment will not be made for assistance with the tasks of communication, community integration, money management, shopping, social appropriateness, and transportation.

If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement. The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency. The narrative must also be attached to the client's individual care plan when it is submitted to the State.

Once an individual or their legal representative selects a provider, they acknowledge on the care plan that they made an independent choice. In addition, the client is given a Client Rights and Responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, provider complaints and grievance administration, Adult Protective Services and the Surveillance Utilization Review Administrator for the Department of Health and Human Services.

During client interviews, performed by the State Medicaid agency, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a client is not aware of their rights it is addressed with the case management entity and included as a finding on the review report. The case management entity is then required to provide a corrective action plan.

The HCBS Case Manager is required to use one of their required home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid Agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that the recipient's health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained the recipient.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that monitors them for compliance.

The cost of this service is limited to a maximum monthly cap set by the State Medicaid agency or through legislative action.

Payment for family personal care is only made to individuals who have individually enrolled as Qualified Service Providers with the State Medicaid office. These providers are required to submit claims via our North Dakota Medicaid Management Information System (MMIS). The MMIS system contains edits that would not pay a provider who is no longer enrolled or is not authorized to provide the service. The system also contains edits to assure that we are only paying the rate that was authorized. Payment is also limited to the services listed on the care plan. Every

provider receives a copy of the authorization to provide services before they are eligible to provide the service. The authorization lists the allowable task, rate and service authorization period. Qualified Service Providers are required to maintain records and are subject to the provider review process.

Payment for Residential Habilitation and Community Supports is only made to agencies who have individually enrolled as Qualified Service Providers with the State Medicaid office. These providers are required to submit professional claims via our North Dakota Medicaid Management Information System (MMIS). The MMIS system contains edits that would not pay a provider who is no longer enrolled or is not authorized to provide the service. The system also contains edits to assure that we are only paying the rate that was authorized. Payment is also limited to the services listed on the care plan. Every provider receives a copy of the authorization to provide services before they are eligible to provide the service. The authorization lists the allowable task, rate and service authorization period. Qualified Service Providers are required to maintain records and are subject to the provider review process.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

All providers including relatives and legal guardians are required to meet the same provider qualifications as all non-relative providers. All providers are required to keep documentation and are subject to provider reviews.
Payment may be made to a legally responsible person if the recipient chooses them as their provider and if the provider meets all of the required qualifications to enroll as a Qualified Service Provider for Family Personal Care, or Waiver Personal Care. If the legally responsible person wants to become the provider and has decision making authority over the recipient the case manager must pre-approve the arrangement. The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency. The narrative must also be attached to the clients person centered plan when it is submitted to the State.

Extraordinary care consists of personal care or similar services and includes assistance with the ADL's/IADL's of bathing/ hygiene, dressing, incontinence care, toileting, transferring/positioning, mobility and feeding/eating. It also includes assistance with the tasks of eye care, medication assistance, cognitive supervision, exercise, Hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthetic orthotics, suppository/bowel program, ted socks, vital signs, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage and specialty bed. Payment will not be made for assistance with the tasks of communication, community integration, money management, shopping, social appropriateness, and transportation.

Once an individual or their legal representative selects a provider, they acknowledge on the care plan that they made an independent choice. In addition, the client is given a Client Rights and Responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, and who to contact with complaints and grievances.

During client interviews, performed by the State Medicaid agency, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a client is not aware of their rights it is addressed with the case management entity and included as a finding on the review report. The SMA provides education to the case manager as a corrective action.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid Agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that the recipient's health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained the recipient.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that monitors them for compliance.

The cost of this service is limited to a maximum monthly cap set by the State Medicaid agency or through legislative action.

Payment for family personal care is only made to individuals who have individually enrolled as Qualified Service Providers with the State Medicaid office. These providers are required to submit claims via our North Dakota Medicaid Management Information System (MMIS). The MMIS system contains edits that would not pay a provider who is no longer enrolled or is not authorized to provide the service. The system also contains edits to assure that we are only paying the rate that was authorized. Payment is also limited to the services listed on the care plan. Every provider receives a copy of the authorization to provide services before they are eligible to provide the service. The authorization lists the allowable task, rate and service authorization period. Qualified Service Providers are required to maintain records and are subject to the provider review process.

If the legally responsible person wants to provide family personal care services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement. The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing

the services is in the best interest of the client to the State Medicaid Agency. The narrative must also be attached to the client's individual care plan when it is submitted to the State.

Payment for Residential Habilitation and Community Supports is only made to agencies who have individually enrolled as Qualified Service Providers with the State Medicaid office. These providers are required to submit professional claims via our North Dakota Medicaid Management Information System (MMIS). The MMIS system contains edits that would not pay a provider who is no longer enrolled or is not authorized to provide the service. The system also contains edits to assure that we are only paying the rate that was authorized. Payment is also limited to the services listed on the care plan. Every provider receives a copy of the authorization to provide services before they are eligible to provide the service. The authorization lists the allowable task, rate and service authorization period. Qualified Service Providers are required to maintain records and are subject to the provider review process.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Qualified Service provider enrollment is available on the online portal. Interested can get assistance the QSP Hub which offers 1 on 1 assistance and education to potential and currently enrolled providers.

Qualified Service Providers are required to complete online training and orientation to show competency before they are able to enroll as a provider. Any interested agency or individual may obtain a provider enrollment packet, upon request, from the QSP Hub. In addition, during community presentations, the State offers information on how to apply to be a provider. Provider enrollment handbooks are also available on the online and by request.

Enrollment is open to all entities that meet the standards and requirements. NDAC 75-03-23-07 details the requirements, application process and appeal rights. Application materials are available on request or on-line. The qualified service provider, including any employees of an agency designated as a qualified service provider are required to meet all licensure, certification, or competency requirements applicable under state or federal law and departmental standards necessary to provide care to eligible individuals whose care is paid by public funds. An application is not complete until the individual or agency submits all required information and required provider verifications to the department.

Numerous provider educational opportunities have been provided Statewide they included information on how to enroll as a QSP.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

● **No, the state does not choose the option to provide HCBS in acute care hospitals.**

○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☐ **The HCBS must be identified in the individual's person-centered service plan; and**

☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(C-1) Number and percent of providers who meet provider standards initially and continually and adhere to other standards prior to their furnishing waiver services; N: Number of providers who meet provider standards initially and continually and adhere to other standards prior to their furnishing waiver services; D: Total # of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QSP enrollment records that require proof of an applicable licensure and/or certification training be provided to the State Medicaid Agency before enrollment and reenrollment.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C-2 Number and percent of non-licensed/non-certified providers who continue to meet waiver provider standards. N: number of enrolled non-licensed/non-certified waiver providers who continue to meet waiver provider standards. D: Total number of enrolled non-licensed/non-certified waiver providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95% Confidence Level with a +/- 5% Margin of Error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C-3 Number and percent of enrolled Qualified Service Providers (QSPs) that met the provider training requirements for the type of waiver service they provide prior to furnishing waiver services. N: Number of waiver providers that met training requirements. D: Total number of Qualified Service Providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Qualified Service Provider enrollment records

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Upon initial enrollment and every three years thereafter and when required by a revalidation plan or when required by the department

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

All licensed and non-licensed providers must enroll as Qualified Service Providers (QSPs) before they can be reimbursed for providing waiver services. All providers are required to complete provider enrollment applications and submit documentation of applicable licenses and training upon enrollment and re-enrollment. For example, Nurse Managers must provide proof of a valid nursing license to the State Medicaid Agency before enrollment and reenrollment. The State

maintains a database that lists the provider's enrollment date, expiration date, approved services etc. If a provider meets standards based on a license their enrollment date ends the same day as their license thus assuring, they continually meet standards.

Providers are enrolled for 3 years. QSPs are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a QSP. Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment. The SMA responsible to monitor all aspects of provider enrollment including closures, denials and terminations. The State measures how many providers' meets standards by tracking enrollment rates, denials, and terminations.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitors them for compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The State maintains a database that lists the provider's enrollment date, expiration date, approved services etc. If a provider meets standards based on a license or certification their enrollment date ends the same day as their license thus assuring, they continually meet standards.

Providers are enrolled for no more than 3 years or the end date on their documentation of competency whichever comes first. QSPs are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a QSP. Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment. The SMA responsible to monitor all aspects of provider enrollment including closures, denials and terminations, training documentation etc. The State measures how many providers' meet standards and training requirements by tracking enrollment rates, denials, and terminations. Providers will not enroll if they do not meet the State's training requirements. In addition, when person-centered plans of care are submitted, State staff check to make sure that the providers on the plan are enrolled and approved to provide the listed services. If the provider is not enrolled to provide the service, the states web-based case management system does not allow the provider to be authorized to provide the service.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review as part of the web based HCBS Comprehensive Assessment to the State Medicaid agency who monitor them for compliance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Waiver services cannot exceed the amount equal to the highest monthly rate for the highest cost skilled nursing facility unless an exception is granted. This amount may be adjusted upon legislative action. Exceptions to the service limit will only be made upon prior approval from program administration for a reasonable accommodation to exceed the service limit. If the individual needs cannot be met within the service limit and a reasonable modification to exceed the service cap is not granted, the case manager will work with the client to explore other options including admittance to a skilled nursing facility or other program that can meet the individual's needs. The case manager informs the participant of the service limit. If an individual's needs exceed the service limit, they would be issued a denial notice and would have the right to appeal.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

The ND State Medicaid Agency has done a review and analysis of all settings (residential & nonresidential) where HCB services
are provided to eligible clients. The analysis included review of ND Century Code, ND Administrative Code, HCBS policy, onsite
visits to all residential service providers, provider calls, and review of licensing rules, regulations and documentation. Through this process the state has determined the following waver services fully comply with the regulatory requirements because these services are individually provided in the recipient's private residence and allow the client full access to community
living. Recipients get to choose what service and supports they want to receive and who provides them. Recipients are free to
choose to seek employment and work in competitive settings, engage in community life and control their personal resources as
they see fit.

Fully Complaint HCBS Waiver:

- Case Management
- Chore Services
- Emergency Response System
- Extended Personal Care/ Nurse Education
- Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-medical Transportation
- Respite Care
- Specialized Equipment and Supplies
- Transitional Living
- Environmental Modification
- Community Transition Services
- Residential Habilitation Services
- Community Support Services
- Companionship Services
- Waiver Personal Care

The following waiver services are not provided in the individual's private residence but based on our analysis also fully comply.

- Institutional Respite: Short-term relief to full-time care givers provided in a nursing home or hospital - Comply per 42 CFR 441.301(c)(4)-(5):
- Supported employment fully complies because services can only be provided in competitive work settings. This service includes individualized training and is not conducted in a group setting. Receiving this service does not restrict a recipient's full access to community living. Waiver funds are not used to support employment in group homes, training centers or any setting that isolates individuals from the community. Recipients are free to seek competitive employment anywhere in the community and receive supports to sustain that employment. Recipients are free to engage in community life and control their personal resources as they see fit.
- The agency adult foster care model is a new setting where residential habilitation and community supports can be provided.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

North Dakota received its final systemic approval of its Statewide Transition Plan (STP) February 1, 2019. The State Medicaid agency will assure continued compliance with the HCBS settings rule by implementing and enforcing policy that will assure the continued integrity of the HCB characteristic that these services provide to waiver recipients. In addition, the State monitors all individual care plans, conducts case management reviews, client interviews/quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them.

Monitoring contacts for case managers remain at every quarter, with the initial, six month and annual monitoring contacts being conducted in-person and allowing the option for the individual to elect to have the 3- and 9-month quarterly monitoring visits conducted via telephone. With the following parameters.

- If the individual is not verbal or able to communicate via telephone a face-to-face visit is required.
- If the participants care is provided by their legal responsible person, then a face to face would need to be completed to ensure Health, Welfare and Safety.
- If there are concerns or changes in care need, incidents requiring follow-up or complaints regarding care a face-to-face visit would need to be completed.

The agency adult foster care model is a new setting where residential habilitation and community supports can be provided. When the setting is established and prior to the services starting, settings for residential habilitation and Community Support services will be verified as compliant with the HCB settings requirements at 42 CFR 441.301(c)(4)-(5). Residential habilitation and community supports may be provided in an individual's private residence and may be provided an agency adult foster care
setting only once deemed fully compliant.

Site Specific Assessments:
The Department will conduct site visits, interviews with licensed providers, and observation of the provision of services in all settings where residential habilitation or community support services may be provided.
Department staff will conduct conference calls and/or site visits with all residential habilitation and community support service providers to specifically review the settings rule as it relates to their facility and provide guidance on areas that need to be changed in order comply with the rule.

Department staff will then complete an initial site-specific assessment of all settings where residential habilitation or community support services may be provided under the HCBS Medicaid waiver that serves the aged and disabled. The assessment will include a site visit, interview with key staff, facility policy or procedure review and observation of the provision of services in all settings.

The Department created Settings Rule assessment tool that will be completed with each facility to help identify areas of noncompliance. Residential Habilitation and Community Support Service providers will be given a copy of the results to help them plan their remediation efforts and identify timelines to make the necessary changes. Once providers notify the Department that they have resolved any issues of noncompliance Department staff will conduct second site visit to determine if the facility meets compliance.

Once this process is complete, the information is reviewed by an the HCBS Settings Administrator and if there are any concerns the findings are reviewed with the internal HCBS settings committee. The committee is comprised of a representative from the State's Aging Services Division, Developmental Disabilities Division, Medical Services Division, and the State Risk Manager. The committee will determine if the setting is compliant and notifies the provider of the decision.

Ongoing Monitoring:
The Department will ensure continued compliance with the HCBS settings rule in all of the States 1915
(c) Medicaid waivers by
implementing and enforcing policy that will ensure the continued integrity of the HCB characteristics that these services provide to waiver recipients. The Department will review all future settings where waiver services will be provided and where waiver participants will reside to ensure that the settings meet the home and community-based settings requirement. The Department will assure continued compliance with all federal regulations. The Department will ensure that the experiences of individuals receiving HCBS in non-residential settings should be consistent with how those settings would be experienced by individuals who are not HCBS service recipients, such as access to food. Appropriate policies and procedures will reflect this requirement.

The Department will use several practices at the recipient, provider, and state level to assure ongoing monitoring and compliance with all home and community-based setting requirements. The Department monitors all individual person-centered service plans, conducts quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them. The Department monitors all settings restrictions to determine if the restriction is necessary and appropriate in accordance with the specifications in the rule. The Department reviews all settings restrictions are documented in the person-centered plan, and the individual has been provided informed consent for the restriction. The ongoing monitoring applies to all settings, including settings that are presumed to comply with the HCBS setting rule, and settings that are presumed to have institutional characteristics and are subject to the CMS heightened scrutiny review. The Department may make a presumption that privately owned or rented homes and apartments of people living alone or with family comply. The state will assure compliance through ongoing monitoring of the client's experience. This can be accomplished through ongoing consumer and family training and contact with case managers trained on the HCBS setting requirements. If there is a presumption that a privately-owned setting is institutional in nature, the case manager will be required to report that to the Department who will take steps to conduct a heightened scrutiny review to assure compliance.

At the recipient level, the State will monitor all individual person-centered service plans, conduct case management reviews, client interviews/quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them. Department staff will complete surveys with the consumers and/or legal decision makers to gather their input on their experience and how the setting is complying with the rule. Consumer surveys are voluntary, and the results are linked to each specific setting to help determine compliance. Case Managers will monitor ongoing recipient experience and setting requirements at required face-to-face visits.

The Department conducted statewide trainings with HCBS Case Managers in annually on the HCBS setting requirements and the person-centered service planning requirements. Training of Department staff, HCBS Case Managers, and the LTC Ombudsman will continue annually using a settings training module. The HCBS settings criteria has been incorporated into the HCBS Case Manager training and into the initial training for the LTC Ombudsman.

Person-centered service plans have been updated and comply with the federal requirements as of July 2015. Setting requirements have been added to the provider standards for enrollment. State staff will conduct site visits of facilities upon initial enrollment and at renewal to assure compliance. A summary of site visits results will be posted on Department's website. In addition, the HCBS setting rule requirements have been incorporated into the licensing criteria for all Agency Adult Foster Care homes where residential habilitation and/or community support services are provided. Compliance will be assured initially upon licensure and then annually during first year of licensure and every 2 years thereafter.

The HCBS Case Managers are responsible to assure ongoing compliance with all Medicaid recipients through monitoring done during their required quarterly monitoring contacts and biannual face to face visits to conduct the person-centered care plan meeting. Case Managers are also required to monitor during their required biannual face-to-face contacts to ensure an individual is being afforded the rights of privacy, dignity and respect, and freedom from coercion and restraint (including the limited use of restraints that are allowable under Adult Residential Services). Any violation of a waiver recipient's rights must be reported as complaint to the Department and/or Vulnerable Adult Protective Services. The Medicaid Waiver Quality review is completed annually with the waiver participant. The questionnaire is embedded in the web based HCBS Comprehensive assessment. A copy of this review is sent to the Department and reviewed by an HCBS Program Administrator. Any issue identified in the client interview must be reported to the Department who will be responsible to work with the licensed provider to remediate any issues or violations related to the setting rule.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☑ **Each individual has privacy in their sleeping or living unit:**

☑ **Units have entrance doors lockable by the individual.**

☑ **Only appropriate staff have keys to unit entrance doors.**

☑ **Individuals sharing units have a choice of roommates in that setting.**

☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Care Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☑ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Registered Nurse HCBS Case Managers are required to have at least a bachelor's degree in Nursing.

☑ **Social Worker**
Specify qualifications:

Social Worker licensed to practice social work in North Dakota and who has met all the requirements as outlined in NDAC 75-03-23 and agreed to comply with policy.
Requires staff person with one of the following:
ND Licensed Baccalaureate Social Worker (LBSW)
ND Licensed Master Social Worker (LMSW)
ND Licensed Clinical Social Worker (LCSW)

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

The State Medicaid agency allows entities to provide both case management and direct waiver services only when no other willing and qualified providers are available to provide culturally competent services as a safeguard for potential clients who are eligible Tribal members where access to culturally competent qualified providers is an issue. In order to provide culturally competent services, the State Medicaid agency enrolls Tribal Nations to provide both case management and direct waiver services to eligible Tribal members.

Safeguards to ensure that service plan development is conducted in the best interest of the participant include:

Individuals or their legal representative choose their own qualified service provider (QSP) from a list provided to them or may recruit an individual who is willing to seek the designation as a QSP. The QSP list is updated by State office staff on an ongoing basis and includes the following information: provider name and contact information, provider type, provider number, provider approved service(s) and applicable rates, and provider (approved) global endorsements. Individuals use the information on the list to make an informed decision. Clients check on the care plan that they choose their own provider. Clients are provided with information that they have the right to choose their own provider during the person-centered planning process.

Once an individual or their legal representative selects a provider, they acknowledge on the care plan that they have also made an independent choice of services. The client signs a Client's Rights and Responsibilities form, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints, concerns and grievances directly to the State Medicaid agency. The form includes the contact information for who to contact for each type of concern or complaint.

During client interviews, performed by the State Medicaid agency, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a client is not aware of their rights the State Medicaid agency addresses the issue with the case manager and includes it as a finding on the review report with a corrective action plan.

The State Medicaid Agency requires a separation of who conducts the work. The person who provides case management cannot be the same person that provides direct waiver services to waiver recipients. All providers must keep service records that include the name of the person who provides the service including case management entities that also provide other HCB services. Annual Case management audits will include a record review that the same individual who provides case management is not also proving other HCB services. The annual audit also ensures the recipient has signed the Client's Rights and Responsibilities form. All person-centered plans of care are reviewed and approved by state aging services staff.

Recipients are informed during the care plan meeting that if they have a dispute with the entity that provides their case management and direct services, they can contact the State directly to assist with a resolution. Recipients are provided with the State's toll free number and other contact information.

The state has historically not had individual providers for case management. All case management providers are currently state employees as the state is the only willing and qualified provider to deliver case management in the state. Changing to Administratively claiming for the statutory tasks of case management including service plan development aligns with how case management is provided in the state through other waivers.

Case management services in the waiver allows agencies that have knowledge and experience of providing culturally competent services that including the tasks of Support Coordination (care coordination) and bolsters the ability to provide additional service beyond the statutory service requirements of case management and assist waiver eligible individuals by promoting health equity, health literacy and cultural humility. In addition, these providers will link waiver participants to other federal, state and local programs. SMA employed HCBS Case Manager is responsible for care plan development, assessment, monitoring, and completing the plan.
Waiver Case Management (HCBS Care Coordination) with the task of support coordination would work to support the individual in receiving LTSS in a cultural appropriate. Care Plan development remains with the SMA.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Clients can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Comments, questions and statements are addressed to the recipient. Recipients are allowed to respond in their own words and at their own pace. The recipient input is considered to be the most important; other team members act as advisors. Meetings focus on strengths and goals of the recipient. Clients choose the service and provider and how much of the care plan to share with team members. If interpreters are needed, they are provided.

Case management is responsible to provide the client with information on the type of services available through various sources (paid & unpaid) including the waiver. Information is gathered through the Comprehensive Assessment which includes an instrument used to record basic demographic and medical information about an individual, including age, date of birth, cultural and linguistic preferences, marital status, living arrangements, emergency contacts, medical resources, health care coverage, functional assessment and source and reason for referral; and to secure measurable information regarding:

a. Acute and chronic health conditions including hearing, speech and vision needs;

b. Medications;

c. Cognitive functioning;

d. Mental and behavioral health;

e. Alcohol, smoking and illicit substance use;

f. Activities of daily living;

g. Instrumental activities of daily living;

h. Informal support;

i. Medical service use and contact information including emergency department services, hospitalization, home health, skilled nursing facility, paid home healthcare, and other therapy providers;

j. Individual specific needs including, global endorsements, supervision;

k. Community, public, managed care and social participation and engagement and risk factors;

l. Risk assessment, health and safety plan including health, medical and nutrition, physical health, cognitive and behavioral health and lifestyle, medications, services and economic assistance, home and physical environment, abuse, neglect or exploitation concerns;

m. Financial resources;

n. Adaptive equipment and technology;

o. Advanced care planning

p. Caregiver assessment (for paid live-in caregivers); and

q. Other information about the individual's condition not recorded elsewhere.

Clients choose the service that they feel will most appropriately meet their needs. When a client chooses waiver services, the client or their legal representative signs on the person-centered plan of care their choice to receive waivered services. Definitions of the services that are available under the waiver are included on the back of the Clients Rights and Responsibilities form. The participant that they have recieved their rights and responsibilities brochure with the signature of the care plan. The document informs the client or their legal representative that they have a choice of receiving the

services listed on the individual care plan or to receive services in a nursing home. It also informs them of their right to consult with whomever they wish before making this decision including family, friends and advocacy organizations.

The Case
Person-centered plan of care includes a summary of the needs and service options identified in the comprehensive assessment and the plan of care for an individual seeking or receiving home and community-based services including:

a. Individual needs, preferences and goals;

b. Formal and informal service and support, paid and unpaid;

c. Service plan;

d. Medical service provider;

e. Contingency plan;

f. Barriers to community-based services and goals;

g. Hospital and skill nursing care admissions;

h. Legal decision making and advanced care planning;

i. Contacts; and

j. Program assurances.

Individuals are given a copy of the Client Rights and Responsibilities brochure; it outlines client rights and responsibilities, and the case manager's responsibilities. The individual care plan is developed with the client and or their legal representative, case manager and anyone else the client chooses to include in the process. Once developed, the client or their legal representative signs that they are in agreement with the plan of care. The plan is also signed by individuals or entities responsible for implementing the plan through accepting authorization in the web-based case management system. A copy or certain portions of the plan are provided to those individuals as directed by the recipient and or their legal representative.

In order to provide culturally competent services, the State Medicaid agency enrolls Tribal Nations to provide both case management and direct waiver services to eligible Tribal members.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

When an individual applies for services through the aged and disability resource link (ADRL) centralized intake, specially training staff receive referrals from individuals interested in HCBS services. The case manager initiates the person-centered planning process by scheduling a meeting with the client and or their legal representative and any other individual that the client wants involved in the process. Clients can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Care plans are developed at least annually or when significant changes occur. However, the client can request meetings and revise the plan at any time. Clients who have communication issues are provided auxiliary aides or interpreters who speak their primary language to facilitate their full participation in the planning process. Cultural preferences are acknowledged, and accommodations are made when necessary.

NDAC 75-03-23 PROVISION OF HOME AND COMMUNITY-BASED SERVICES UNDER THE SERVICE PAYMENTS FOR ELDERLY AND DISABLED PROGRAM AND THE MEDICAID WAIVER FOR THE AGED AND DISABLED PROGRAM is cited for state law that affects service plan development.

The case manager conducts a comprehensive assessment in the home where the services are delivered. The comprehensive assessment includes the following elements:

"Comprehensive assessment" means an instrument used to record basic demographic and medical information about an individual, including age, date of birth, cultural and linguistic preferences, marital status, living arrangements, emergency contacts, medical resources, health care coverage, functional assessment and source and reason for referral; and to secure measurable information regarding:

a. Acute and chronic health conditions including hearing, speech and vision needs;

b. Medications;

c. Cognitive functioning;

d. Mental and behavioral health;

e. Alcohol, smoking and illicit substance use;

f. Activities of daily living;

g. Instrumental activities of daily living;

h. Informal support;

i. Medical service use and contact information including emergency department services, hospitalization, home health, skilled nursing facility, paid home healthcare, and other therapy providers;

j. Individual specific needs including, global endorsements, supervision;

k. Community, public, managed care and social participation and engagement and risk factors;

l. Risk assessment, health and safety plan including health, medical and nutrition, physical health, cognitive and behavioral health and lifestyle, medications, services and economic assistance, home and physical environment, abuse, neglect or exploitation concerns;

m. Financial resources;

n. Adaptive equipment and technology;

o. Advanced care planning

p. Caregiver assessment (for paid live-in caregivers); and

q. Other information about the individual's condition not recorded elsewhere.

The Charting the Lifecourse/Nexus Vision Tool; the vision tool includes 8 domains assessing the individuals strengths, needs, preferences, and goals. The 8 domains include;

- Daily life and employment domain encompassing school and education, life-long learning, employment, volunteering, routines and life skills;
- The Community Living domain encompasses housing, home adaptations, home modifications, community access, and transportation;
- The Social Support and Spirituality domain encompasses friends, relationships, leisure activities, personal networks and faith community;
- Healthy living is inclusive of medical, mental and behavioral health needs, nutrition, wellness, access to health care, health care needs, physical health information, functional impairments, current health status, medication use, health risk factors, falls, and cognitive decision making;
- The Safety and Security domain encompasses emergencies, legal rights and issues, legal representative issues, financial concerns, mental/behavioral health related safety concerns, cognitive issues, fire safety;
- Advocacy and engagement include assessment and facilitated discussion on citizenship, valued roles, making choices, setting goals, the individuals views and responsibilities, leadership, and peer support;
- Supports for family and/or natural supports includes understanding what the individual wants regarding to family involvement and engagement in their supports and services; All providers and services that will best meet the individual's needs and whom the individuals receive cares are documented in the Services and supports domain;)
- Supports and Services encompasses details on formal and natural support providers and services that support the individual needs and/or wants to live as independently as possible, and what the possibilities are for securing the needed supports.

This assessment process also includes an assessment of the person's strengths and needs. Recipients are asked to describe their preferences, and goals are developed and documented in their own words including any desire for employment or alternative housing. Mechanisms for solving conflict and disagreement during the process are outlined during the meeting including discussing any conflict of interests.

Interim care plans may be developed for clients who require services immediately, or who are affected by natural disaster or other emergencies once Medicaid waiver eligibility has been determined, and the case management entity is not able to make a face-to-face visit on the day the service is requested. Interim care plans may also be used to ensure continuity of waiver services during a disaster or other emergency if the incident occurs at the time the annual service plan needs to be reviewed and updated and the case manager cannot make a face-to-face visit as required. Interim care plans can begin the day that the consumer is found to be eligible for waiver services, and cannot extend beyond the first 60 days of their annual care plan year, at which time the full comprehensive care plan must be implemented in order to continue the delivery and reimbursement of waiver services. When services are needed immediately the case manager will need to complete a face-to-face visit and complete an assessment within 10 working days of the request. During natural disasters or other emergencies, a face-to-face visit must be made within 60 days of the request. Prior approval from the Department is required.

All contacts relating to the client must be noted in the narrative section of the comprehensive assessment. Information that must be contained in the note includes the date, reason for contact, location of the visits, a description of the exchange if face-to-face between the case manager and the client or collateral contact, description of clients environment, appearance, and communication style, a list of identified needs, service delivery options, summary of the agreed upon care plan, client stated goals, progress, or change in goals, client satisfaction, a statement about the adequacy of the services and whether or not the provider is providing the service in the amount, duration, and frequency expected. A follow-up plan addressing any issues must also be included in the narrative.

Participants are informed of home and community-based services that are available in their communities (paid and unpaid) including services that are available under the waiver during the assessment process.

The case manager works with the HCBS participant and the person-centered team to develop the person-centered plan of care which includes a summary of the needs and service options identified in the comprehensive assessment including:

a. Individual needs, preferences and goals;

b. Formal and informal service and support, paid and unpaid;

c. Service plan;

d. Medical service provider;

e. Contingency plan;

f. Barriers to community-based services and goals;

g. Hospital and skill nursing care admissions;

h. Legal decision making and advanced care planning;

i. Contacts; and

j. Program assurances.

On the individual care plan, the case manager lists other agencies and individuals who are providing services to waiver participants including informal supports. The individual care plan lists the type of service, provider's name, units of service authorized, the provider's rate and the total cost of care.

Participant goals and needs (including health care needs) are discussed during the assessment. Clients choose the type of service that will best meet their individual needs and choose who provides the care. All providers and services both paid and unpaid are listed. Client stated goals are documented on the individual care plan and reviewed at least every six months. The individual care plan reflects that the recipient chose the setting in which they reside and also includes a list of the person's strengths and positive attributes. The plan identifies potential risks and any approach that has been taken to mitigate those risks. Any deviation from helping the client to achieve their goals or assure their health and safety must be documented in the plan. The plan must include information on how safety needs were assessed based on the client's abilities and current condition as well as other restrictive interventions and methods that were tried first but were not successful. The plan must include documentation of a timeline for a periodic review of these modifications to determine if they are still necessary to assure health and safety. Recipients must be fully informed of the plan and any modifications made to their stated preferences or goals to assure safety. Documentation must be included to assure that the intervention will not cause harm to the recipient.

The case manager monitors the plan quarterly or more frequently if necessary to assure services are being delivered in the amount, scope and frequency stated in the care plan, and that progress toward desired goals is being met. Other individual or entities that are responsible for carrying out portions of the care plan are listed. Anyone involved in carrying out the plan must receive a copy of the plan or a portion of the plan as determined by the recipient. The care plan is updated on an annual basis and is reviewed at six months. Case managers are required to conduct quarterly monitoring visits with the recipient. The recipient can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Case management activities may occur more frequently if applicable. Clients can request a meeting to discuss or modify the plan at any time. Clients are made aware of their responsibility to participate fully in the care plan process and its implementation.

1/1/2026 The state is removing the face-to-face requirement for quarterly monitoring visits. Quarterly monitoring visits will still be required. Minimum frequency of face-to-face visits would be every 6 months.

The web-based Home and Community Based Services (HCBS)Person Centered Plan of Care is required for all clients receiving HCBS under the Medicaid Waiver. It is to be completed initially and revised or updated as client's needs warrant. It is to be reviewed with the client at the annual and six-month review and complete a new form if necessary due to changes in service(s) and/or amounts. During the assessment and care planning meetings conducted by the case manager, the needs are determined by the assessment tool and person-centered planning. The provider signs and agrees to provide the services as listed on the person-centered plan of care and authorization to provide services through viewing and accepting the services through the Electronic Visit Verification (EVV) system, or if the provider

is not utilizing the state EVV provider they sign the authorization accepting the responsibility of providing the services on the person-centered plan of care. All person-centered plans of care are reviewed and approved by the Adult and Aging Services Staff.

Electronic signatures are permitted based on State policy.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☑ **Informed consent of the individual.**
- ☑ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Through the comprehensive needs assessment, potential risks are identified. Including but not limited to risks related to financial concerns, legal issues, fire safety, falls, access to health care, family issues, informal/community/social supports, mental health/behavioral health needs, cognitive decision making, nutrition, medication, employment, education, and housing. The case manager and client will review the assessment results and develop the risk assessment and care plan to diminish risk. The individual care plan lists potential risks and any approach that has been taken to mitigate those risks. Any deviation from helping the client to achieve their goals or assure their health and safety must be documented in the plan. Case managers must include information on how the safety needs were assessed based on the client's abilities and current condition as well as other interventions and methods that were tried first but were not successful. The plan must include documentation of a periodic review of these modifications to determine if they are still necessary to assure health and safety. Recipients must be fully informed of the plan and any modifications made to their preferences or goals to assure safety. Documentation must be included to assure that the intervention will not cause harm to the recipient.

Case management works with the individual and the person-centered planning team to develop a person-centered plan that addresses the health and welfare of the individual. Identified health, welfare and safety risk through the comprehensive assessment and care planning are addressed in, a risk assessment and safety plan. The risk assessment and safety plan includes documentation of the participants risks, participants action/inaction, the possible negative outcomes and alternative measures that may be implemented by the participant or formal and informal supports to ensure the continuity of services. The risk assessment and safety plan is integrated to the person centered plan of care.

If a participant chooses an individual provider, the client and the case manager establish a contingency plan that is documented on the individual care plan. The contingency plan may include contacting another provider, family member, community resource, or if the service is not critical, rescheduling the service to be provided at another time. When individual providers enroll as Qualified Service Providers, they are required to state what they will do in the event that they are not able to provide the service as scheduled. If a participant chooses an agency provider it is the responsibility of that agency to send a replacement or if the service is not critical, to contact the client and reschedule.

Both individual and agency providers make assurances when they enroll with the State Medicaid Agency that they will contact the case managers when changes occur in the client's health status or service needs.

The State Medicaid agency conducts case management reviews, provider reviews, and client interviews to identify inappropriate service delivery or actions and to address the client needs and satisfaction with the services.

The HCBS Case Manager is required to conduct a quality review that is embedded in the HCBS Comprehensive Assessment with the recipient annually. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipients home as scheduled; c) The environment and recipients appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other restrictive interventions. Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

A Qualified Service Providers (QSP) list is maintained by State office staff and readily available in the web-based provider database. The web-based searchable public database is available on the Department's website to assist individuals in finding a QSP. This list includes information about all providers who are currently enrolled to provide services and who choose to have their information shared with the public. The information contained in the QSP list includes: provider name and contact information, provider type, provider number, provider approved service(s), applicable rates, and provider (approved) global endorsements.

This list is shared with clients so they can choose a provider and is used by the case managers to assure that providers are eligible to provide the type of service being authorized. The individual checks and signs the care plan indicating they were afforded the opportunity to choose their service provider(s). When requested, Case Managers may assist recipients in contacting providers to check their availability. Case managers may also advocate for the clients by contacting community providers who are not currently enrolled as Qualified Service Providers to see if they would be willing to enroll and serve waivered recipients.

The web-based provider database also includes updated information on renewals, newly enrolled, and recently closed QSP thus assuring that clients have access to the most current list of providers available.

When a change in service provider occurs between case management contacts, the client or legal representative may contact the case manager requesting the change in provider and the contact is verified in the case manager's documentation. A copy of the updated person-centered plan is sent to the client or legal representative.

Applicants/Clients may also recruit potential service providers. Case managers often help individuals identify family, friends, neighbors etc. that may be willing to provide care. The potential providers must comply with provider enrollment standards and requirements. If a potential provider is identified, the applicant may obtain a copy of the enrollment handbook from the QSP Hub.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

All person-centered plans are required to be submitted to the State Medicaid Agency through the web based case management system. HCBS Program Administration has full access to reviews the care plans. Issues relating to inconsistencies or incompleteness are returned to the case management entity or individual for resolution.

The comprehensive assessments/narratives are also available through a web-enabled data system accessible to the Aging Services Division/HCBS staff.

These tools are used in case management reviews performed by the Department. The comprehensive assessment, individual care plans, authorizations, and other applicable information are used to determine services have been appropriately authorized by the case management entity.

All case management entities are reviewed each year, either through an on-site or desk review. In addition, a statistically significant number of waiver assessments/care plans are reviewed via desk review by State Medicaid Agency staff. These reviews are conducted annually.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case management entity is responsible to monitor the person-centered plan and participant health and welfare. If the client's care needs cannot be met by the care plan and health, welfare and safety requirements cannot be assured; case management must initiate applicable changes or terminate Waiver services. If the case is closed, the client is made aware of their appeal rights.

The client's legal representatives, and family, also play a significant role in monitoring the care plan. The client or legal representative report changes to the case manager relating to the client's home, self, living arrangement, or service provision for care plan evaluation and revision.

Monitoring contacts are required quarterly. The HCBS participant has the choice of the quarterly monitory contact being face to face or via telephone. At least one home visit is required during the needs assessment process. Case management contacts occur after 30 days (phone or face to face) from the initial care plan implementation and at least quarterly thereafter. Case management activities are not limited to quarterly contacts and additional contacts may be initiated when change is required in the care plan, a concern has been identified or at the request of the recipient.

The State monitors case management contacts. Monitoring methods are determined by reviewing the comprehensive assessment and care plan. Care planning is a process that begins with assessing the client's needs, goals and personal preferences. It includes the completion of the HCBS comprehensive assessment at which the case manager and client look at the needs and situations described in the comprehensive assessment and any other problems identified and work together to develop a plan for the client's care. All needs are identified in the comprehensive assessment and the services authorized to meet those needs are identified on the person centered plan of care plan. Additional information regarding needs and consumer choice is outlined in the narratives in the HCBS comprehensive assessment. For each functional impairment identified for which a service need has been authorized, a desired outcome and assistance required to achieve the outcome will be addressed in the notes/narrative section of the comprehensive assessment. For each ADL or IADL that is scored impaired and no waiver services have been authorized, the case manager documents how the need is being met. The case manager discusses options for long term services and supports and the individual chooses the services and scope of the tasks they would like to meet their needs.

The HCBS case manager reviews with the client or the client's representative the following information about qualified service providers (QSPs) who are available to provide the service and who have the endorsements required to serve the client:
- Provider name and contact information
- Provider type
- Provider number
- Provider approved service(s)
- Applicable rates

The eligible provider selected by the client will be listed on the individual care plan. The service (paid & unpaid), amount of each service to be provided, the costs of providing the selected services, the specific time period, and the source(s) of payment are also recorded on the individual care plan, and the authorization to provide service.

Contingency planning must occur if the QSP selected is an individual rather than an agency. The backup provider or plan must be listed on the individual care plan. Agency providers are required to coordinate staff to assure service availability.

The case manager shall review with all clients or the client's representative the client stated goals. The goals must be recorded on the person centered plan of care on an annual basis. The final step in care planning is to review the completed individual care plan with the client /legally responsible party and obtain required agreements/acknowledgments and signatures.

The case manager assures that services are implemented and existing services continued, as identified in the individual care plan through monitoring. This activity includes contacting the QSP and issuing an authorization for service(s) form.

Service monitoring is an important aspect of care planning and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The case manager monitors the client's progress/condition and the services provided to the client. As monitoring reveals new information to the case manager regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case manager shall document all service monitoring activities and findings in the client's case file. When completing monitoring tasks, if the

case manager suspects a QSP or other individual is abusing, neglecting, or exploiting a recipient of HCBS, an established protocol must be followed.

HCBS Case Managers are required to conduct a quality review with the recipient annually. Using a quality questionnaire developed by the Medicaid agency the case managers conducts recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration and frequency as required by the care plan; b) Arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount outlined in the care plan; d)The services and amount of services meet the client's needs e)The available services meet the recipient's needs and assure that health, welfare and safety needs are met; e) The provider is not taking or using the recipient's property; f) The provider treats the recipient with respect; g) The provider has never injured the recipient; and h) The provider has never restrained or secluded the recipient or used other restrictive measures.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. The case manager reassesses the client, care plan, goals, and services on an annual basis. At the annual visit, the client stated goals must be reviewed and progress or continuation of the goals must be noted on the care plan.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

Safeguards are in place to ensure that monitoring is conducted in the best interest of participants. The safeguards include the option for individuals or their legal representatives to choose a Qualified Service Provider (QSP) from a list provided to them or to recruit an individual who is willing to seek the designation as a QSP. Once an individual (or their legal representative) selects the provider of their choice, they acknowledge on the person centered plan that they made an independent choice of that provider. In addition, the client is given a Client's Rights and Responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

The State Medicaid agency conducts client interviews either in person or virtually a portion of the review sample. Clients are asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a provider is not aware of their rights, it is addressed with the case manager included as a finding on the review report.

HCBS staff complete a review of each case manager on an annual basis. If findings are identified corrective action plans are required. HCBS staff also review all individual care plans to assure that the client has acknowledge their choice of provider.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-1) Number and percent of face-to-face quality reviews that determine if all individual's assessed needs including health, welfare, and safety (H,W&S) needs are being addressed. N: Number of face to-face quality reviews that determine all individual's assessed needs including H,W&S needs are being addressed. D: Total number of face to face quality reviews reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**
	☑ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
(D-2) Number and percent of waiver recipients service plans that address the individual's goals identified through the assessment process. N: Number of service plans that address the individual's goals identified through the assessment process. D: Total number of service plans reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope,***

amount, duration, and frequency specified in the service plan.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-3) Number and percent of the participant plans are updated at least annually or when the participant's needs change. N: Number of participant plans updated annually or when a participant's needs change. D: total number of participant plans requiring an update due to a change in need or up for annual review that were reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-4) Number and percent of client reviews that determined services are being

delivered by the type, scope, amount, duration and frequency specified in the care plan. N: Number of client reviews that determined services are being delivered by the type, scope, amount, duration and frequency specified in the care plan. D: Total number of client reviews that were reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error.
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: HCBS Case Managers	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Reviews are completed the first and third year of the renewed waiver. Reports/data will be compiled at that time.

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-5) Number and percent of waiver recipients who are afforded a choice between/among waiver services and providers. N: number of waiver recipients who are afforded a choice between/among waiver services and providers. D: Number of waiver recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Level with a +/- 5% Margin of Error.
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The State will complete desk reviews of a statistically significant number of HCBS waiver recipient's assessments/care plans annually to determine if needs have been assessed according to policy and procedures. The State will also review 100% of the HCBS waiver files to determine if they have a current care plan.

Statistical significance for the desk review of assessments/care plans will be determined by calculating a representative random sample of current waiver recipients based on credible parameters including a 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution.

The HCBS Case Manager is required to use one of their required home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitor them for compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

State Medicaid Agency staff are responsible for addressing individual problems regarding care plans. Remediation techniques include but are not limited to providing one on one technical assistance, group training, adding information to the case management update that is emailed to all case managers, issuing corrective actions including the submission of missing or incomplete information, and recoupment of funds and or case management fees if necessary.

Problems identified during the quality review must either identify a remediation plan and/or must be reported to the State as a complaint. State Medicaid Agency staff are responsible for addressing all complaints. The State maintains a complaint database to track complaints by the date the complaint was received and responded to, and by type and resolution. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Case reviews will be conducted of a statistically valid number of waiver files annually.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An applicant requesting Home & Community Based Waiver services completes an application form. The application form contains information pertaining to consumer rights and explains the procedure clients may follow in the event they are not satisfied and wish to request a fair hearing. This form is signed and dated by the consumer or their legal representative.

Individuals are informed that they have an opportunity to request a fair hearing when they are not given the choice to receive waiver services, are denied waiver services or providers of their choice, or their waiver services are suspended, reduced or terminated.

On the individual care plan the client must check both: I am in agreement with the services and selected the service providers listed above and I am in agreement with this plan. If either of these two acknowledgments are not checked and signed by the client or the clients legal representative the client or the legal representative must be given a completed termination, denial or reduction form to inform the client of their right to a fair hearing. The form includes contact information for the appeals supervisor. The care plan is signed and dated by the client or the legal representative at least every six months.

When an applicant/client is denied HCBS or if their services have been terminated or reduced, they are provided with the SFN 1647 HCBS Notice of Denial, Termination or Reduction form. If an applicant/client services are reduced, denied or terminated, they are informed of the timeline necessary to submit an appeal. Waiver recipients are also notified via the SFN 1647 that if a Medicaid appeal is received before the date of the termination is effective, services can continue until a hearing decision has been made. If the State Medicaid agencies decision is upheld, the client will be required to reimburse the State Medicaid agency for services provided after the termination date.

Copies of all SFN 1647 forms are kept in the client's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The State Medicaid agency uses a multi-disciplinary team approach if a complaint/grievance is received. When an HCBS Administrator receives a complaint, staff will assess the situation and arrange a team consult if needed.

At times, the team will be comprised of other HCBS team members, Medical Services Administration Unit Staff, Case Managers, Vulnerable Adult Protective Services, Health Department, Protection & Advocacy, and Long Term Care Ombudsman. Others may be involved depending on the situation.
QSP Complaint Policy can be referenced in the HCBS policy manual 525-05-45

Grievance system policy can be referenced in the HCBS policy manual 525-05-43 with full implementation of the federal requirements referenced in https://public-inspection.federalregister.gov/2024-08363.pdf no later than 12/31/2027
HCBS policy manual https://www.nd.gov/dhs/policymanuals/52505/52505.htm

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department accepts any complaint received. When a participant notifies the State Medicaid agency of a grievance or complaint, the complaint is received, evaluated, applicable records relating to the complaint are reviewed, collateral information is obtained from the involved persons, and resolution is sought. If the complaint identifies immediate risk or harm to the client, law enforcement is involved as appropriate. Other complaints are responded to based on severity or within 14 days. If the complaint is related to a denial, reduction, or termination of services, the client is informed that this process is not a pre-requisite or substitute for a fair hearing.

A tracking system is maintained of the complaints and grievances, type of complaint, and the resolution.

Members and their legal decision maker, who are receiving services that are authorized through a 1915c waivers and funded through Medicaid, have the right to submit a grievance. A grievance may be filed at any time during HCBS participation.

A grievance is a way a member and/or legal decision maker can tell the state about a concern they have on how care is provided. A grievance can be raised by either the member or their legal representative. The grievance may be about the care planning process, the person-centered plan, or living arrangements. This process makes sure concerns are heard, reviewed, and resolved.

The types of grievances that a member and/or legal decision maker may submit include, but are not limited to concerns with;

- Person-Centered Planning process
- Implementation of the Person-Centered Service Plan
- Provider performance, service delivery of the person-centered plan
- Home and Community Based Setting (HCBS) rules compliance
- Transition

The HCBS Case Manager or HCBS Supervisor may assist with the individual to file a grievance upon request.

A Qualified Service Provider (QSP) Complaint is any issue that involves a Qualified Service Provider (QSP) that affects eligible HCBS participants quality of care, health/welfare/safety, inappropriate billing, potential fraud/waste/abuse, or failure to meet/maintain enrollment standards.
Complaints are categorized by the nature of the complaint which include the following areas.

- Absenteeism
- Abuse/neglect/ exploitation
- Breach of confidentiality
- Criminal History/Activity
- Disrespectful
- Inappropriate Billing
- Care Unacceptable to the Department
- Property Damage
- Self-Neglect
- Providing care under the influence of drugs/alcohol
- Medication errors that result in adverse effects
- Not submitting a critical incident report (this was new to report on in the 2023, 372 report)
- Not submitting or following through with the QI Program

A complaint can be made by any person with knowledge of misconduct by a Qualified Service Provider (QSP) or QSP agency.

- o A complainant may choose to remain anonymous.
- o Case managers are required to report QSP complaints to Aging Services.
- o HCBS Quality Reviews (QR) are completed by a HCBS case manager on an annual basis with the HCBS Comprehensive Assessment. If the QR includes any concerns about a QSPs performance as a provider, concerns about abuse/neglect/exploitation perpetrated by a QSP, or other issues that involve a QSP provider, the HCBS Case Manager must submit a QSP Complaint through the ADRL.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant.

Reportable incidents include:
•Policy includes: Abuse (physical, emotional, sexual, verbal and psychological), neglect, or exploitation;
•Rights violations through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation, or policy;
•Serious injury or medical emergency, which would not be routinely provided by a primary care provider;
•Wandering or elopement;
•Restraint violations (misuse or unauthorized use of restrictive interventions or seclusion);
•Death of a waiver recipient and cause;
•Report of all medication errors, omissions or missing medications; and
•Any event that has the potential to jeopardize the waiver recipient's health, safety or security if left uncorrected.
•Changes in health or behavior that may jeopardize continued services.
•Illnesses or injuries that resulted from unsafe or unsanitary conditions.

An HCBS Program Administrator will be responsible for following up on reported incidents. Within 24 hours or one business day of receiving the report from the HCBS case manager, the department will submit a medical case incident report for incidents involving suspicious deaths and events that have the potential for litigation or legal involvement into the web-based critical incident reporting System.

If the case involves abuse, neglect or exploitation, a formal VAPS referral will be initiated according to ND Century Code 50-25.2-03(4). If the incident involves a provider, the complaint protocol will be followed to determine the next steps, which may include involving law enforcement. The Program Administrator, Director of Aging Services, Vulnerable Adult Protective Services Program Administrator, LTC Ombudsman, and Risk Management will meet quarterly to review all incident reports related to waiver recipients to determine trends, need for education, additional services, etc.

All reports must be filed within five (5) days of the incident.

The State of North Dakota has a mandatory reporting law for reporting suspected abuse or neglect of an adult. The law requires certain professions including qualified service providers, nurses, nursing home personnel, hospital personnel, occupational therapists, physical therapists, physicians, social workers and other to report abuse, neglect, and exploitation of vulnerable adults. Any other person may voluntarily report to the ND Department of Health and Human Services or to law enforcement. A mandated reporter must report if in an official or professional capacity, he or she:
•Has knowledge that a vulnerable adult has been subjected to abuse or neglect; or
•Observes a vulnerable adult being subjected to conditions or circumstances that reasonable would result in abuse or neglect.
•Mandatory reporters are required to report as soon as possible.
•Any person required to report who willfully fails to do so is guilty of an infraction and subject to a fine of up to $1,000.

Reports are submitted using a standardized online reporting tool or phone call with a central intake staff member. Guidelines and flow charts have been developed to help reporters know where to send their information and what type of information should be included. The Department distributes information about the mandatory reporting law to all QSPs including those that provide care to waiver recipients and has provides outreach and training to make people aware of this fraud, waste and abuse and mandatory reporting laws.

The State Medicaid agency has written policies detailing the process of monitoring for abuse, neglect, or exploitation of all waiver participants. Policy states that the case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the State Medicaid agency. When case managers become aware of an incident, State law and policy requires that they gather specific information and report it to the appropriate party.

Incidents may include abuse, neglect, or exploitation. Abuse means the willful act or omission of a caregiver or any other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation to or of a vulnerable adult. Neglect means the failure of a caregiver to provide essential services necessary to maintain physical and mental health of a vulnerable adult; or the inability or lack of desire of the vulnerable

adult to provide essential services necessary to maintain and safeguard the vulnerable adult's own physical and mental health. Exploitation is the act or process of an individual using the income, assets, or person of a resident for monetary or personal benefit, profit, gain, or gratification.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported. Incidents involving unauthorized use of restraints must be reported per the requirements listed in Section G-2-a-i.

In addition to the mandatory report to the Department of Health and Human Services and depending on the situation, the case management entity could also potentially report the incidents or suspicions to tribal entities, State Regional Human Service Centers, Vulnerable Adults Protective Services, Long Term Care Ombudsman, Health Department, Protection and Advocacy, law enforcement, and/or the State Medicaid agency. In addition these same entities report suspected abuse, neglect, or exploitation of waiver participants to case management entities and or the State. This sharing of information helps to assure the timely resolution of concerns.

In between formal contacts by the case manager clients are made aware that they can contact the case manager to report any concerns. During client interviews conducted by the State Medicaid agency staff, clients are asked if they know the name of their case manager and how to reach that individual. This helps to assure that the client will know whom to call to report an incident when one occurs instead of waiting until the case manager contacts them. In addition, family, friends, advocacy groups and other service providers report complaints to the case managers and or the State Medicaid agency.

Providers are subject to the mandatory reporting law and agree when they enroll to report potential abuse or exploitation when they become aware of the incident to the case manager.

Clients are provided with a copy of the client rights and responsibilities form. The form contains contact information for the case manager, appeal supervisor and the Executive Director of the Department of Health and Human Services. Clients may contact either of these individuals or the State Medicaid agency to report an incident that involves the nurse or case management. If a complaint is received in regard to a nurse or case management entity State Medicaid office staff work with the case managers supervisor and others to resolve the situation.

Substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, arrest by law enforcement. If allegations are found to be unsubstantiated, the complaint is logged in the complaint database and no further action is taken.

The information is typically received via telephone or e-mail. However, information can also be obtained from letters, face-to-face contact, the review process, or through general discovery.

The HCBS Case Manager is required to use one of their required home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid Agency, the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitor them for compliance.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid Agency per policy. These conditions or practices must be abated or eliminated

immediately or if applicable within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error within five days of the incident. The State Medicaid Agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The clients, or their legal representatives, will receive a Client's Rights and Responsibilities brochure describing their rights and their responsibility to self-report when they are approved for services. The Rights and Responsibilities brochure notes they have a right to privacy, dignity, and respect; be free from unlawful discrimination; be free from abuse, neglect, and exploitation; have property treated with care; and be free from coercion. Case managers list their name and contact information for the case management entity on the form. Case Managers are required to have quarterly contact with all waiver recipients. One of those visits is used to conduct an annual quality review where clients are asked specific questions about potential abuse, neglect, exploitation and have a conversation about the quality of their care. During all other contacts case managers are also required to discuss any issues the clients may be having with their care and address and follow up on all problems identified.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department of Health and Human Services receives all mandatory reports of suspected abuse, neglect or exploitation of a vulnerable adult. According to North Dakota Century Code 50-25.2-03 (4), a report shall be made "as soon as possible". If a mandatory report investigation determines that the vulnerable adult is a waiver recipient or if the allegation involves a qualified service provide the State Medicaid Agency is also notified. Case managers are also required to provide a report of abuse, neglect or exploitation to the State Medicaid agency if the vulnerable adult in the situation involves a recipient or qualified service provider. The HCBS staff person follows through by working with the case manager to assist with the investigation of the complaint or concern identified. Depending upon the incident, there are several entities that are alerted about the allegations. If the accused person is not a provider, the complaint is referred to the Vulnerable Adults Protective Services for resolution. If the accused is a provider the HCBS program staff person works with the case manager and determines a resolution. If the case involves an individual with Developmental Disabilities the DD Division and Protection and Advocacy are contacted for resolution. If the case involves Adult Foster Care (AFC) clients the licensing agents responsible for AFC licensing are contacted for resolution. If the case involves a client residing in a Basic Care or Assisted Living Facility the Long Term Care Ombudsman is contacted for resolution and depending on the concern, the North Dakota Department of Health or the Departments Agent responsible for Assisted Living Licensure may be involved. If the complaint presents an imminent risk, or potential criminal activity is suspected, law enforcement is immediately contacted by the case manager.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency per policy. These conditions or practices must be abated or eliminated immediately or if applicable within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error within 5 days of the incident. The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

In addition, the nurse who provides the training for attendant care services is required to maintain records related to:(1) the nursing activities that were taught to the attendant care provider and written instructions for the required tasks, (2) the re-evaluation of the client's needs through an annual nursing assessment and any additional need for training of the attendant care provider (3) incidents that result in client injury or require medical care. The nurse must also provide written documentation to the State Medicaid agency that shows he or she has provided instructions to the attendant provider that outlines the types of situations that are considered reportable incidents. Attendant providers must also immediately report incidents that result in client injury or require medical care to the client's primary care provider. If the HCBS case manager and State Medicaid agency staff determine that the incident is indicative of abuse, neglect, or exploitation, the appropriate protocol for abuse neglect resolution will be followed.

If a complaint involves the provision of home delivered meals Aging Services Division, Department of Health or United States Department of Agriculture (USDA) would be contacted depending on whether the provider was a hospital, nursing home, basic care facility, OAA nutrition provider, ND licensed food establishment or facility regulated by the USDA.

If a complaint involves a case manager, State Medicaid Agency staff are responsible to investigate the incident and may involve the case manager's supervisor and other entities as appropriate.
Policy dictates that case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the State Medicaid agency. Response time to all other complaints and concerns are responded to within 14 days.

The incident could result in continued monitoring, termination of providers, removal of client(s) from residences, arrest by law enforcement, or if allegations are not supported, it is considered unsubstantiated. When appropriate, either the case manager or the State Medicaid agency will inform interested parties including the client or responsible party of the resolution of the complaint.

The State Medicaid Agency may require the provider to submit a written plan to abate or eliminate immediately, or within a fixed period of time the practices or conditions that resulted in the incident.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is

conducted, and how frequently.

In addition to the information supplied in the previous sections, the State Medicaid agency may also conduct on-site reviews of a service provider or on-site client interviews if there is an allegation of a critical incident.

If the incident involves the assistance of Protection and Advocacy, a Department of Health and Human Services Long Term Care Ombudsman and Health division representative, HCBS Administration Unit or Medical Services, the State will contact these individuals for assistance in the assessment/evaluation of the allegation. These various entities would then determine if separate on-site investigations should occur.

Case Managers are required to submit the results of the quality reviews conducted with waiver recipients to the State Medicaid agency who will monitor them for compliance. If an immediate threat to the recipient is identified case managers will be required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported and will be responded to per the complaint policy.

Qualified Service Providers that have 24-hour responsibility for the medication administration of waiver recipients (i.e., adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency per policy. Conditions or practices that are adversely affecting the provision of medication administration must be abated or eliminated immediately or if applicable within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error within 5 days of the incident. The State Medicaid agency will review medication error reports for compliance and corrective efforts.

If an allegation involves the case manager, the State Medicaid agency is responsible to respond to the complaint. The State Medicaid agency may involve the case managers supervisor, human service zone boards or other interested parties as appropriate.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

● **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The use of restraints is only permitted during the course of the delivery of Adult Residential Services. Restraints may not be used in any other setting where waiver services are provided. Adult Residential Service facilities must be licensed as Basic Care facilities in accordance with ND Admin Code 33-03-24.1-03. Adult Residential facilities must act in accordance with resident rights which comply with NDCC 50-10.2 and ND Admin Code 33-03-24.1-09 (2) (h). NDCC 50-10.2-02 (1) (k) states that residents have "The right to be free from mental and physical abuse and the right to be free from physical or chemical restraint except in documented emergencies or when necessary to protect the resident from injury to self or to others". Administrative code also dictates that any use of restraints must be authorized and documented by a physician for a limited period of time and, if the restraint is a chemical one, it must be administered by a licensed nurse or physician. Except as provided in this subdivision, drugs or physical restraints may not be used or threatened to be used for the purposes of punishment, for the convenience of staff, for behavior conditioning, as a substitute for rehabilitation or treatment, or for any other purpose not part of an approved treatment plan.

Before restrictive emergency procedures can be implemented as described in the administrative code it is the responsibility of the case manager to assess and document the restriction plan on the person-centered plan of care. This plan is reviewed quarterly. The case manager will document the maladaptive behavior and the identified restriction. Less restrictive methods must be included in the plan and attempted prior to the application of restraint. Previous restriction plans must be identified in the plan. The emergency use of restraints must be developed with the participation of the waiver recipient and/or their legal decision maker who must consent to the plan. The HCBS Program Administrator reviews all plan of care and will approve the plan of care if it contains all of the required information.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported. Some Adult Residential facilities have a no-restraint policy if a recipient chooses such a facility it will be documented in the plan of care.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported.

The use of all unauthorized restraints (those not written into the individual's plan, or those that do not follow the requirement of NDCC 50-10.2-02 (1) (k)), must be abated or eliminated immediately and meet the criteria of a Serious Event. These situations must be verbally reported to the HCBS Case Manager and Aging Services immediately. A incident report must also be submitted in writing to Aging Services within 24 hours of the incident. The Aging Services Team will review all incident reports to determine if restraints were used appropriately. If it is determined that restraints were used appropriately it will be documented in the recipient's narrative. If it is determined restraints were not used appropriately, and in accordance with state law, a formal referral to VAPS and/or ND Department of Health (licensing entity) will be initiated. VAPS and/or ND Department of Health will be responsible for independent review and follow up.

The Aging Services Team consists of the Aging Services Director, HCBS Program Administrator, Aging Services Program Administrator licensed as an RN, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the HCBS Case Manager. The HCBS Case Manager must also review the plan of care on a quarterly basis to assure the safeguards and requirements are met and to assure that the approval of the individual and/or legal decision maker is documented. This information is recorded in the narrative and any noncompliance or needed follow up regarding the use of restraints are initiated and documented.

The Critical Incident Reporting Team reviews all critical incidents, including unauthorized use of restraints, on a quarterly basis. The team determines trends, need for education, additional services, and ensure proper protocol has been followed. The data collected includes: client name, date of incident, name of provider and/or witness, if the incident was suspected abuse, neglect or exploitation and other details of the incident. The critical incident report data is tracked on an internal Excel spreadsheet.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

- (●) **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The ND Department of Health and Human Services (DHHS) monitor the use of restrictive interventions in residential facilities and through Adult Foster Care licensing. DHHS monitors the use of any type of restrictive interventions in adult residential settings through a survey process. In addition, the State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of restrictive interventions is considered to be part of the definition of abuse. Therefore, case managers are also responsible to report the use of restrictive interventions as a part of the monitoring process to assure health, welfare and safety. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

● **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The ND Department of Human Services and the Department of Health monitor the use of seclusion in residential facilities and through Adult Foster Care licensing. The Department of Health monitors the use of any type of seclusion in adult residential settings through a survey process. In addition, the State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of seclusion is considered to be part of the definition of abuse. Therefore, case managers are also responsible to report the use of seclusion as a part of the monitoring process to assure health, welfare and safety. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of

a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ● **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

  i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- Basic Care Facilities that provide Adult Residential Services have ongoing responsibility for medication regimen based on their Basic Care Licensure. Each Basic Care facility is licensed annually by the Department of Health, Division of Health Facilities. Unannounced onsite surveys are conducted each year on approximately 1/3 of the Basic Care Facilities. Complaints are received by the Division in any form, and are investigated by unannounced onsite visits. When non-compliance is identified the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all five components of a plan of correction are represented in the plan. Revisits are conducted on all citations to verify implementation of the plan of correction and that the implementation has indeed corrected the problems identified. All Basic Care facilities are surveyed ever two years for compliance to life safety code requirements.

Basic Care survey process consists of several tasks, Sub-Task 5E - Medication Pass deals with medication management. The medication pass portion of the survey is described below.

Sub-Task 5E Medication Pass: A. General objective is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice. B. General Procedures: Record observations and the physicians actual order. When observing the medication pass, do the following: Be as neutral and unobtrusive as possible; Observe a minimum of 10 opportunities for errors; Strive to observe as least two individuals administering medications; Ask the person administering the medication if they know what the medication is and what it does and how the person was trained. Verify the training and competency of the person who administered the medications.

- There is an enforcement process that can be applied to basic care facilities that are unwilling or unable to achieve and maintain compliance. Facilities are subject to one or more enforcement actions, which include: A ban or limitation on admissions, suspension or revocation of a license or a denial to license, for the following reasons:(1).Noncompliance with the requirements of this chapter have been identified which:(a) Present imminent danger to residents.(These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department);(b) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or (c) Have a potential for jeopardizing resident health, safety, or security if left uncorrected.

- Swing bed facilities that provide respite care have ongoing responsibility for medication regimen based on their licensure as a hospital.
If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification compliance. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health. Hospital swing bed facilities must follow the hospital or Critical Access Hospital (CAH) conditions of participation in addition to swing bed requirements. Onsite surveys are conducted based on criteria set by the Centers for Medicare and Medicaid Services (CMS). All surveys, including complaints, are conducted without announcing the survey to the facility.
Hospital survey process consists of several tasks: Task 1 Offsite Survey Preparation; Task 2 Entrance Activities
Task 3 Information Gathering/Investigation; Task 4 Preliminary Decision Making and Analysis of Findings;
Task 5 Exit Conference
Task 6 Post Survey Activities. All surveys include record review, interviews and observation of care and services provided.

When non-compliance is identified, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed and determined acceptable only after all components of a plan of correction are represented in the plan. Revisits are conducted on all deficiencies to verify implementation of the plan of correction and that the implementation has corrected the problems identified.

- Nursing Facilities that provide respite services have ongoing responsibility for medication regimen based on their Nursing Facility Licensure. Each skilled nursing facility is required to be surveyed annually for compliance to the federal Medicare and Medicaid certification regulations. During the annual survey, Sub -task 5E is conducted as part of the routine survey process. Sub -task 5E is the medication pass determination for compliance and an explanation of the task is written below.

Sub-Task 5E - Medication Pass and Pharmacy Services:

A. Objectives: To determine whether the facility safely administers medications including: Accuracy of medication administration; Labeling that contains at least the name and strength/concentration of the medication, as well as expiration date when applicable, Security of medications to determine: whether medications are stored and handled in accordance with manufacturers recommendations and/or state or federal requirements; whether the facility reconciles controlled medications, as appropriate; whether the facility obtains the services of a licensed pharmacist; and whether the facility provides or obtains pharmaceutical services, including routine and emergency medications, to meet the needs of each resident.

B. Use: The medication pass and a review of storage and access to medications must be conducted on every Initial and Standard survey; and Revisits, as necessary; Review for the provision of licensed pharmacist consultation on the initial survey and on any other survey type, if the survey team has identified concerns that indicate: That the facility does not have a licensed pharmacist; and/or that the licensed pharmacist may not have performed his/her functions related to the provision of pharmaceutical services; Review for the development and implementation of pharmaceutical procedures if, concerns have been identified regarding: the availability of medications; accurate and timely medication acquisition; receiving, dispensing, administering, labeling, and storage of medications; reconciliation of controlled medications; and the use of qualified, authorized personnel to handle and dispense medications.

C. General Procedures

1. Medication Pass (includes labeling): When observing the medication pass: Be as neutral and unobtrusive as possible; Observe different routes and/or forms of medications; Initially observe the administration at least 20-25 medications; Record, from the medication label, the name and dose/concentration of each medication administered. Also record the route of administration (if other than oral) and the expiration date, if expired; Record all multiples, For liquids, record actual volume, or in the case of items such as psyllium, record number of rounded teaspoonfuls and the amount of liquid; Observe whether staff confirmed the residents identity prior to giving medications and whether the medications were identified up to the point of administration. Record the techniques and procedures that staff used to handle and administer medications; and observe whether staff immediately documented the administration and/or refusal of the medication after the administration or the attempt.

After the medication pass, compare your observations with the prescribers orders. Determine whether there was an error(s) in medication administration i.e. an error in the preparation or administration of medications or biologicals that is not in accordance with any of the following: The prescribers order; Manufacturers specifications regarding the preparation and administration of the medication or biological; Accepted professional standards and principles that apply to professionals providing services.

After completion of the observations and reconciliations, calculate the facilitys medication error rate, if one or more errors are found. If it is determined that the facilitys overall error rate is 5 percent or more, a medication error deficiency exists.

2. Medication Storage (includes labeling): Review medication storage in order to determine whether: Medications and biologicals are accessible only to authorized staff and are locked when not under the direct observation of the authorized staff; Controlled medications are stored in a manner to limit access and to facilitate reconciliation in accordance with the facility policies; Medications are stored to maintain their integrity and to support safe administration of the correct medication to the correct resident, by the correct route and in the correct dose; Medications are not expired, contaminated, or unusable; Medication labels are legible; intact; contain the name and dose/concentration of the medication, appropriate cautionary/accessory instructions, expiration date, and support the safe administration of the medication; and Multi-dose vials are labeled per facility policy and manufacturers specifications once use of the vial has been initiated.

3. Controlled Medications: If a concern regarding controlled medications was identified during the survey process or during the medication pass, interview facility staff, regarding the concern. If a potential problem has been identified regarding lack of reconciliation or loss of controlled medications: Determine whether Scheduled II controlled medications are in separately locked, permanently affixed compartments (or are a minimal amount of unit dose packages); Review the facility procedure and a sample of the reconciliation records, and compare the amount of medication available with the amount the records indicate should be available; and interview the

director of nursing and/or licensed pharmacist regarding: Actual frequency of the reconciliation; How the facility investigates loss or inability to reconcile controlled medications; and How the licensed pharmacist has been involved in recognizing the situation and collaborating with the facility to review and update its practices and procedures.

4. Pharmaceutical Services: If concerns have been identified regarding pharmaceutical services, review the facilitys evidence that they have been receiving ongoing pharmacy consultation regarding all aspects of the provision of pharmaceutical services in the facility. Determine whether the licensed pharmacist is available during the survey or identify how to contact the licensed pharmacist; Review procedures and interview staff regarding the areas of concern.

5. Provision of a Licensed Pharmacist: If there is no licensed pharmacist providing services in the facility, interview the administrator and others, as appropriate, regarding: The length of time the facility has been without the services of a licensed pharmacist; and current efforts underway to obtain the services of a licensed pharmacist.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

North Dakota Department of Health is responsible for oversight of Basic Care Facilities.

Sub-Task 5E Medication Pass

A. General Objective
The general objective of the medication pass is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice. B. General Procedures Record observations. Record the physicians actual order. Do this only if the physicians order differs from the observation of the administration of the drug. When observing the medication pass, do the following:

- Be as neutral and unobtrusive as possible during the medication pass observation.

- Observe a minimum of 10 opportunities for errors (opportunities are both the drugs being administered and the doses ordered but not administered). Strive to observe at least two individuals administering medications if possible. This provides a better overall picture of the accuracy of the facilitys entire drug distribution system Ask the person administering the medication if they know what the medication is and what it does. Ask how the person was trained to administer medication. Ideally, the medication observation could include residents representative of the care needs in the sample. This would provide additional information on these residents, and provide a more complete picture of the care they actually receive. For example, if blood sugars are a problem, insulin administration may be observed. If eye infections are a problem, antibiotic eye drops may be observed, if residents are in pain, as needed pain medications may be observed, etc. Observe different routes of administration, i.e., eye drops, injections, inhalation. The opportunities should equal 50% of the resident census, not to exceed 40 opportunities.

- Verify the training and competency of the person who administered the medications.

- There is an enforcement process that can be applied to basic care facilities that are unwilling or unable to achieve and maintain compliance. Facilities are subject to one or more enforcement actions, which include: A ban or limitation on admissions, suspension or revocation of a license, or a denial to license, for the following reasons:

(1). Noncompliance with the requirements of this chapter have been identified which:
  (a) Present imminent danger to residents. These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department;
  (b) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or
  (c) Have a potential for jeopardizing resident health, safety, or security if left uncorrected.

The North Dakota Department of Health is responsible for the oversight of hospital swing bed facilities.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Swing bed facilities must follow the hospital or CAH conditions of participation in addition to swing bed requirements.

All surveys are conducted using an outcome oriented survey process and include record review, interview and observation.

The Hospital Conditions of Participation require pharmaceutical services meet the needs of the patients by promoting a safe medication use process that ensures optimal selection of medications, dose, dosage form, frequency, route, duration and that substantially reduces or eliminates adverse drug events and duplication of treatment.

The Critical Access Hospital Conditions of Participation also require rules for storage, handling, dispensation and administration of drugs and biologicals. The CAH must ensure the safe and appropriate use of medications and medication-related devices.

Hospital licensing rules require compliance with the pharmacy requirements. When non-compliance is identified

by survey staff, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all components of a plan of correction are represented in the plan.

Revisits are conducted on all citations to verify implementation of the plan of correction and that the implementation has corrected the problems identified.

The North Dakota Department of Health is responsible for the oversight of nursing facilities.

- Nursing Facilities that provide respite services have ongoing responsibility for medication regimen based on their Nursing Facility Licensure. Each skilled nursing facility is required to be surveyed annually for compliance to the federal Medicare and Medicaid certification regulations. All surveys are unannounced. During the annual survey, Sub -task 5E is conducted as part of the routine survey process. Sub -task 5E is the medication pass and pharmacy services determination for compliance and an explanation of the task is written below.

Sub-Task 5E - Medication Pass and Pharmacy Services:

General Procedures

1. Medication Pass (includes labeling): When observing the medication pass: Be as neutral and unobtrusive as possible; Observe different routes and/or forms of medications; Initially observe the administration at least 20-25 medications; Record, from the medication label, the name and dose/concentration of each medication administered. Also record the route of administration (if other than oral) and the expiration date, if expired; Record all multiples, For liquids, record actual volume, or in the case of items such as psyllium, record number of rounded teaspoonfuls and the amount of liquid; Observe whether staff confirmed the residents identity prior to giving medications and whether the medications were identified up to the point of administration. Record the techniques and procedures that staff used to handle and administer medications; and observe whether staff immediately documented the administration and/or refusal of the medication after the administration or the attempt.

After the medication pass, compare your observations with the prescribers orders. Determine whether there was an error(s) in medication administration i.e. an error in the preparation or administration of medications or biologicals that is not in accordance with any of the following: The prescribers order; Manufacturers specifications regarding the preparation and administration of the medication or biological; Accepted professional standards and principles that apply to professionals providing services.

After completion of the observations and reconciliations, calculate the facilitys medication error rate, if one or more errors are found. If it is determined that the facilitys overall error rate is 5 percent or more, a medication error deficiency exists.

2. Medication Storage (includes labeling): Review medication storage in order to determine whether: Medications and biologicals are accessible only to authorized staff and are locked when not under the direct observation of the authorized staff; Controlled medications are stored in a manner to limit access and to facilitate reconciliation in accordance with the facility policies; Medications are stored to maintain their integrity and to support safe administration of the correct medication to the correct resident, by the correct route and in the correct dose; Medications are not expired, contaminated, or unusable; Medication labels are legible; intact; contain the name and dose/concentration of the medication, appropriate cautionary/accessory instructions, expiration date, and support the safe administration of the medication; and Multi-dose vials are labeled per facility policy and manufacturers specifications once use of the vial has been initiated.

3. Controlled Medications: If a concern regarding controlled medications was identified during the survey process or during the medication pass, interview facility staff, regarding the concern. If a potential problem has been identified regarding lack of reconciliation or loss of controlled medications: Determine whether Scheduled II controlled medications are in separately locked, permanently affixed compartments (or are a minimal amount of unit dose packages); Review the facility procedure and a sample of the reconciliation records, and compare the amount of medication available with the amount the records indicate should be available; and interview the director of nursing and/or licensed pharmacist regarding: Actual frequency of the reconciliation; How the facility

investigates loss or inability to reconcile controlled medications; and How the licensed pharmacist has been involved in recognizing the situation and collaborating with the facility to review and update its practices and procedures.

4. Pharmaceutical Services: If concerns have been identified regarding pharmaceutical services, review the facilitys evidence that they have been receiving ongoing pharmacy consultation regarding all aspects of the provision of pharmaceutical services in the facility. Determine whether the licensed pharmacist is available during the survey or identify how to contact the licensed pharmacist; Review procedures and interview staff regarding the areas of concern.

5. Provision of a Licensed Pharmacist: If there is no licensed pharmacist providing services in the facility, interview the administrator and others, as appropriate, regarding: The length of time the facility has been without the services of a licensed pharmacist; and current efforts underway to obtain the services of a licensed pharmacist.

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements at 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. To certify a SNF or NF, at least a: 1. Life Safety Code (LSC) survey; and 2.Standard Survey must be completed. All citations are revisited, the revisit may be onsite or it may be by mail and/or phone.

-Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
A) Result in imminent danger to the health, safety or security of the waiver recipient;
B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
C) Result in the hospitalization of the recipient;
D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately or within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error to the State Medicaid agency within 5 days of the incident.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ● **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

With the exception of extended personal care, adult residential and respite care provided in a basic care, swing bed or nursing facility, N.D.A.C. 75-03-23-07 and the Qualified Service Provider handbook outline the standard for self-administration of medication. A definition of self-administration is located Qualified Service Provider handbook. The definition on the back of the form reads, medication assistance is limited to assisting with client self-administration of routine oral medications by doing the following: opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container.

Information about medication errors concerning medication administration that is authorized as part of a waivered service will be communicated to the State Medicaid agency in the following manner:

- Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
A) Result in imminent danger to the health, safety or security of the waiver recipient;
B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
C) Result in the hospitalization of the recipient;
D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately or within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error to the State Medicaid agency within 5 days of the incident.

- Qualified Service Providers that are authorized to provide medication administration to waiver recipients i.e. extended personal care, and nurse education providers will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
A) Result in imminent danger to the health, safety or security of the waiver recipient;
B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
C) Result in the hospitalization of the recipient;
D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately and reported to the recipient's primary care physician and the Case Manager who will contact the State Medicaid agency. The State Medicaid agency must be contacted within 5 days of the incident.

In addition, a nurse educates the extended personal care service provider about medication administration for a specific client. This activity is governed under N.D.A.C. 55-05-04 of the Nurse Practice Act.

The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

- **Medication Error Reporting.** *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

  Specify the types of medication errors that providers are required to record:

  Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
  A) Result in imminent danger to the health, safety or security of the waiver recipient;
  B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
  C) Result in the hospitalization of the recipient;
  D) Result in a sentinel event i.e. death of a waiver recipient

• **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

North Dakota Department of Health is responsible for oversight of medication administration in Basic Care Facilities N.D.A.C. 33-03-24.1-10. & Nursing Facilities protocol is provided in G-3-b-ii.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Hospital licensing rules require compliance with the pharmacy requirements. Protocol provided in G-3-b-ii.

Medication errors or omissions that occur during the provision of waivered services must be reported to the State Medicaid agency per the policy described in G-3-c-i. The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

In addition, Medication administration for extended personal care services is taught to the extended personal care service provider by a licensed nurse and this activity is governed under N.D.A.C. 55-05-04 of the Nurse Practice Act. The nurse gives instructions for medication administration based on the needs of a specific client and at a minimum, re-evaluates the client's needs every six months to determine if additional training is required or, whenever the client or legally responsible person notifies the nurse that a new medication has been ordered by a physician.

For all other waiver services N.D.A.C. 75-03-23-07 and the Qualified Service Provider handbook outline the standard for self-administration of medication. Medication assistance is limited to assisting with client self-administration of routine oral medications by doing the following: opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container. If incidents are reported relating to self-administration of medication they are handled through the complaint process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-1)Number and percent of reported complaints that were addressed by State Medicaid Agency (SMA) within the required 14 day timeframe. N: Number of reported complaints addressed by SMA within 14 day timeframe D: Total number of reported complaints to SMA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint database maintained by State

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe

		Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-2)Number and percent of providers submitting an assurance to the State Medicaid Agency (SMA) that they will report medication errors or omissions per policy. N: Number of providers that submitted an assurance to the SMA that they will report medication errors or omissions per policy. D: Total number of providers authorized to provide medication administration as part of a waivered service.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Qualified Service Provider (QSP) records

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Upon initial enrollment and re-enrollment(every two years)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-3) Number and percent of unexplained deaths where proper follow-up(e.g reporting, referral, investigation) was completed within required timelines. N: number of unexplained deaths where proper follow-up(e.g reporting, referral, investigation) was completed within required timelines D: total number of unexplained deaths.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: HCBS Case Managers	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-4) Number and percent of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. D: All reports where abuse, neglect or exploitation are substantiated.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check*	**Sampling Approach** *(check each that*

each that applies):	*each that applies):*	*applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-5) Number and percent of investigated ANE/Serious event reports where risk management steps were implemented. N: number investigated ANE/Serious event reports where risk management steps were implemented D: all investigated ANE/Serious event reports reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-6)Number and percent of instance of abuse, neglect, exploitation and unexplained deaths reviewed for by the State Medicaid Agency (SMA) N: Number of instance of abuse, neglect, exploitation and unexplained deaths reviewed for by the SMA. D: Number of instances of abuse, neglect, exploitation and unexplained deaths reported.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-7) Number and percent of critical incidents where the root cause was identified. N: Number of critical incidents where the root cause was identified. D: Number of critical incidents reported.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-8)Number and percent of incidents where use of restraint was substantiated through investigation, where follow-up was completed as required. N = Number of incidents where restraints were used, where follow-up was completed as required. D = Total number of incidents where restraints were used.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-9 # and % of participants' family/guardian (F/G) that indicate during the annual quality review (AQR) that people paid to help with their svc have never used restrictive intervention (RI) incl. seclusion. N: # and % of waiver recipients F/G that indicate during the AQR that people paid to help with their svc have never used RI incl. seclusion. D: Total # of waiver recipient's F/G who had an AQR.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-10)Number and percent of reported complaints regarding restraints that were substantiated through investigation, where follow-up is completed as required. N: Number of reported complaints regarding restraints that were substantiated through investigation where follow-up is completed as required. D: Total reported complaints regarding restraints that were substantiated through investigation.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(G-11) Number and percent of waiver recipients who receive the rights and responsibilities brochure annually. N: number of waiver recipients who receive the rights and responsibilities brochure annually. D: Number of waiver recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence

		Interval = 95% Confidence Level with a +/- 5% Margin of Error
☑ **Other** Specify: HCBS Case managers	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

A "reported complaint" is any complaint or grievance that was reported to the Department of Human Service's via phone, fax, email, in person contact or collateral contact. The Department accepts and reviews all complaints and must follow up on the complaint within 14 days of receiving it. Any State staff person can receive a complaint but there are two State staff designated to follow up on all complaints and make sure that the process is completed. These staff lead the process but a team approach is used to determine corrective actions etc. If the follow-up was not completed as required, the SMA would make a determination if the provider's enrollment status will be affected.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including seclusion and/or restraint. Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. The use of all unauthorized restraints (those not written into the individual's plan, or those that do not follow the requirement of NDCC 50-10.2-02 (1) (k)), must be abated or eliminated immediately and meet the criteria of a Serious Event. These situations must be verbally reported to the HCBS Case Manager and Aging Services immediately. A incident report must also be submitted in writing to Aging Services within 24 hours of the incident. The Aging Services Team will review all incident reports to determine if restraints were used appropriately; it will be documented in the recipient's narrative. If it is determined restraints were not used appropriately and in accordance with state law, a formal referral to VAPS and/or ND Department of Health (licensing entity) will be initiated. VAPS and/or ND Department of Health will be responsible for independent review and follow up.

All providers who administer medications (i.e. adult residential providers, extended personal care and basic care, swing bed and nursing home facilities that provide respite care) will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
A) Result in imminent danger to the health, safety or security of the waiver recipient;
B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
C) Result in the hospitalization of the recipient;
D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately. Providers must report the error within five days of the incident per policy. The HCBS Case Manager must report hospitalizations to the State Medicaid Agency.

In addition, all waiver recipients are also given a participants rights brochure that is explained to them by the Case Manager. The brochure includes information on how to report a complaint.

As soon a HCBS case manager learns of a waiver recipients death they must immediately report the death by providing the recipients' name, date of death, cause of death, location of death and any other pertinent information to the State Medicaid Agency. A Aging Services HCBS Program Administrator is then responsible to submit a Medical Services incident report. The incident report is sent to staff from the Department's Risk Management unit, Legal Advisory unit and the Director of Aging Services. The incident report will be reviewed upon receipt to determine if the circumstances surrounding the death

are suspicions. If yes, the complaint protocol will be followed to determine the appropriate next steps which may include but are not limited to involving law enforcement. Quarterly this group will also meet to review all incident reports related to waiver recipient deaths to determine trends, need for education, additional services etc.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. If an immediate threat to the recipient is identified case managers will be required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy.

State Medicaid Agency staff are responsible for addressing all complaints. The State maintains a complaint database to track complaints by the date the complaint was received and responded to, and by type and resolution. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

The State Medicaid agency reviews medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

The State Medicaid Agency will review all reported waiver recipient deaths. If issues are identified remediation techniques may include referral to law enforcement, need for additional education, provider termination etc.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: HCBS Case Managers	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State Medicaid agency is responsible for evaluating the effectiveness and outcomes of the discovery, remediation, and quality improvement plans. The State prioritizes its remediation efforts to address any problems that involve client care or health and welfare issues first. The State keeps track of its quality improvement efforts by maintaining databases and statistics that include applicable time frames for completion. The State uses this information to make necessary changes to improve quality.

When pre-determined (QA) goals are not met or problems (that are not directly related to client care or health welfare and safety issues) are identified, the State discusses the issue(s) at team meetings and develops a plan of action. If the problem involves client care or health welfare and safety issues the problem is addressed immediately.

The action plan is documented in the team meeting minutes and may include, publishing the results of our quality improvement efforts in the HCBS Update that is provided to all Case Management entities, addressing unmet goals at the next Case Management training, rewriting updating policy/protocol as applicable.

Tools and/or instruments may also be revised to accommodate new measures. Annual letters are sent to all providers to provide them with information, make them aware of common errors and new requirements. If improper payment activities have occurred, adjustments to claims are processed, funds are recouped and providers may be placed on review or terminated if necessary.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: continuously & ongoing

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

System design changes are monitored by the HCBS team and discussed at HCBS team and administrative meetings. The State maintains a quality assurance plan that describes system improvements and other remediation efforts. The State keeps track of identified problems and tracks the number of errors that are identified over time. If no improvement is seen new strategies are put in place.

The home and community base services (HCBS) team includes staff members from Aging Services Division responsible for administering Federal and State funded HCBS and the Medical Services Division - HCBS Administration unit, Money Follows the Person Program Administrator, the State Unit on Aging Director, and the Medical Services Director or Assistant Medical Services Director.

The core HCBS team consists of the Aging Services Director who has overall responsibility for the team, five HCBS Program Administrators, three nurse HCBS Program Administrators, one Program Specialist and two office assistants. One of the Human Service Program Administrators IV (HSPA IV) is the team lead and administers policies and programs for all services including the administration of the state funded services. This individual supervises the Human Service Program Administrators III (HSPA III) positions. These positions have general responsibility for any system changes made to the monitoring assessing and reviewing system design and processes, quality assurance, provider billing, rate setting and provider audits.

The three other Human Service Program Administrator HSPA IV position are Registered Nurse that is responsible for reviewing critical incidents the Adult Foster care, Extended Personal Cares program, residential habilitation, community supports and companionship program administration. These position is responsible for system design changes that would involve waiver amendments and certain aspects of the quality assurance process.

In addition, there is a qualified service provider enrollment team who has responsibility as it relates to the QSP enrollment process.

The HCBS Unit of the ND Medical Services Division has partnerships with other Units within the Medical Services Division. External resources are vital to the development of effective and efficient services. These entities participate as applicable: Human Service Zone Boards, service providers, family members, consumers, Long Term Care Association, advocates, and other interested parties.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The States quality improvement strategy is discussed during team meetings and administrative meetings that are scheduled quarterly. System changes and common errors or individual problems that have been identified via the audit process are also discussed. Once a year the State calculates statistics and reviews the results of the quality improvement plan. Trends are tracked and reviewed against the previous years results to see where improvements have been made and where future quality improvement efforts need to be focused. The results of this analysis are discussed with the HCBS team and the adult services committee and distributed to Case Managers through the quarterly update. Issues regarding recipient health, safety, and welfare are addressed immediately.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**

Other *(Please provide a description of the survey tool used):*

We utilize internal tools that include quality of life information that are completed annually and as part of on-site case management audits.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Department of Human Services currently has approximately 1500 enrolled Qualified Service Providers (QSPs) including case management entities. Waiver providers are not required to secure an independent audit of their financial statements and not all providers are subject to a single State audit.

The State Medicaid agency (SMA) completes onsite or desk reviews of all case managers on an annual basis to determine if operational and administrative functions have been carried out according to policy and procedures. In addition, the State Medicaid agency completes desk reviews of statistically valid number of HCBS waiver recipients paid claims data to determine if activities and tasks were billed/paid within allowable limits. The paid claims data review is conducted annually. Sample size for the waiver paid claims review are based on a 95% confidence level and a +/- 5% margin of error based on the number of paid claims during the timeframe of the data pull.

The State Medicaid agency also completes Overtime Audits, Quality Reviews, Reviews all critical incidents, QSP Complaints audits and reviews, grievances, targeted waiver service audits, Settings Rule reviews, EVV Audits and QSP Enrollment compliance audits. The process to choose who will be reviewed from this group is not random. The providers are chosen because irregularities in their billing patterns or other concerns have been identified. Within these reviews, various components are evaluated to determine if activities and tasks were billed/paid within allowable limits. Provider records and logs are evaluated to determine if proper procedure codes were utilized, and services were delivered in accordance with the authorization of services.

The SMA conducts quarterly quality review team meetings. These team meetings include SMA staff responsible for Overtime Audits, Quality Reviews, Reviews all critical incidents, QSP Complaints audits and reviews, grievances, targeted waiver service audits, Settings Rule reviews, EVV Audits and QSP Enrollment compliance audits. The team reviews information on audits completed, any identified program integrity issues, remediation, trends and needs for program and policy development. In addition, the State Medicaid Agency reviews service utilization and costs annually and performs audits of certain services when issues have been identified through discussion team members to have a higher potential for inappropriate billing or other irregularities that would warrant a review of all claims data related to that service. When issues are identified corrective action plans are issued. The reviewer is responsible to follow up with all corrective actions to assure compliance before the review can be closed. Corrective actions may include a referral for quality and/or additional QSP audit may be made if deemed appropriate, Technical assistance, Corrective Action Plan, Recoupment of inappropriate payments, Pre or Post payment review of claims, and other sanctions including termination of provider status.

HCBS Medicaid waiver services are authorized in the MMIS system and created in the case management/EVV provider system, Therap. The service authorization is generated through the Therap system as a preauthorization for services. The preauthorization is sent over to MMIS through an interface which creates the service authorization and is used to verify the information on a professional billing claim submitted by the provider. Services authorizations are required for the following services Adult Day Care, Homemaker, Respite Care, Supported Employment, Adult Foster Care, Chore, Environmental Modification, Extended Personal Care, Home Delivered Meals, Non-Medical Transportation, Specialized Equipment and Supplies, Supervision, Transitional Living, Emergency Response System, Community Transition Services, Residential Habilitation, Community Support, Waiver Personal Care and Companionship Services. If there is not a valid SA in the system, claims will be denied. In addition, if a provider tries to bill over the authorized amount or for a service that is not authorized the claims will be denied. Family Personal Care and Adult Residential Care services do not require an SA because their utilization is controlled through other edits contained in MMIS and through parameters built into the HCBS waiver benefit plan coverage. The number of units is also limited in the system to the calendar month.

The State agency responsible for conducting the state's financial audit is the Office of the State Auditor. An audit of the State of North Dakota Comprehensive Annual Financial Report is conducted annually by the State Auditor's Office. This audit involves examining, on a test basis, evidence supporting the revenues, expenditures and disclosures in the financial statements, assessing the accounting principles used and evaluating the overall financial statement presentation.

An agency audit of the Department of Health and Human Services is performed every two years. This audit is a result of the statutory responsibility of the State Auditor to audit each state agency once every two years and is a report on internal control, on compliance with State and Federal laws, and on efficiency and effectiveness of agency operations.

The State Auditor's Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(I-1) Number and % of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. N: Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. D: Total # of claims reviewed.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =*

		95% Confidence Level with a +/- 5% Margin of Error
☐ ***Other*** *Specify:*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(I-2) Number and percent of provider payment rates that are consistent with the rate methodology approved in the waiver application or subsequent amendment. N: Number of provider payment rates that are consistent with the rate methodology in the approved waiver application or subsequent amendment. D: Total number of provider payment rates reviewed.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	***Frequency of data collection/generation****(check each that applies):*	***Sampling Approach*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☑ ***Representative Sample*** *Confidence Interval =* *95% Confidence Level with a +/- 5% Margin of Error.*
☐ ***Other*** *Specify:*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Statistical significance for the review of paid claims data will be determined by calculating a representative random sample of waiver recipients paid claims data using credible parameters including a 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution. The random representative sample will be calculated from the total number of paid waiver claims for the previous waiver year (for example in waiver year 3 the review will include claims paid in waiver year 2) The state will use a research number randomizer to choose which waiver claims to review.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including seclusion and/or restraint. Case Managers are required to submit the results of the

quality review to the State Medicaid agency who will monitor them for compliance.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

The State is responsible for addressing individual problems. Resolution methods include but are not limited to providing education / technical assistance, rewriting billing instructions/ provider information to increase understanding, sending written corrective action plans to providers, recouping funds, placing providers on review, and terminating provider status if necessary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☑ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

SMA is responsible for rate determination. SMA historically establishes rates by comparing the rates of other similar services, gathers feedback from stakeholders and has engaged in a rate study as part of the rate determination process. Ongoing monitoring of trends in utilization of services and number of providers available to provide the service assists in identifying change that the SMA follows up on as part of the rate determination process. The sufficiency of a rate is determined based on the number of clients who are able to access services including access in rural areas the number of qualified service providers (QSP) enrolled to provide care & public comment.
The Legislative process allows for public comment during appropriation committee hearings. Inflationary adjustments are determined by legislative appropriation and are subject to that public process. (Additional information on public comment is found in Main-B.)

The Department uses a fee for service system wherein the budget for a service is based on the actual service utilization and costs. The rate for each service is non-negotiable. These rates are determined based on legislative appropriations and only updated when the legislature approves the amount of change. Initial rates were established for each service based on actual cost reports for other similar services and adjusted with legislatively approved provider increases. Individual QSPs and the agency FFS rate was based on actual costs & includes allowable admin costs to the agency. Allowable admin costs include indirect cost of providing services: salaries, fringes, recruiting, phone billing, office space utilities, janitorial bonding & liability insurance. The rate methodology as established historically is unchanged.

Additionally, rates are reviewed every two years while building the departments' budget request for legislation review. This includes reviewing the average rates per service and utilization. The Legislative process allows for public comment during appropriation committee hearings. Inflationary adjustments are determined by legislative appropriation and are subject to the public input process including public input meetings.

Individual and Agency rates have historically been & were inflated forward by 3% to reflect historical LEG rate increases. 3% is based on historical annual rate increases granted to waiver providers by the legislature.

The rates were applied for 9 months of each waiver year based on historical rate increases granted to waiver providers. Inflation was added for 9 months each year because rate adjustments are historical made in Jul of each year. QSPs are notified they must charge private pay clients at a rate equal to or greater than the rate set with the State. In all cases the QSP is notified of the initial rate & is notified when the rate changes.

Waiver personal care, homemaker, supervision, respite care, chore, companionship services, non-medical transportation, extended personal care/nurse education non-rural differential rates are a blended average of the agency and individual current fee for service rates paid for each service. The average RD rates for these services were calculated in the same way but an average of the agency and individual current fee for service RD rates paid for each service was used.

Transitional Living service can only be provided by an agency and therefore the cost per unit is based on the current agency rate. The average RD rate for this service was calculated in the same way but an average of the agency RD rate was used.

Adult residential services, emergency response, environmental modification, and specialized equipment and supplies were calculated using an average of all of the rates paid for each service. The list of rates is maintained by the State Medicaid Agency. This method was used because the rates for these services are unique to each provider or client.

Agency case management costs per unit were determined by calculating an average of the current annual agency assessment rate and the current agency case management rate paid for all other agency case management contacts historically as there are no current providers for this service.

Community transition services was calculated based on historical data of the number of units multiplied by the rate of the transitions from nursing facilities under the Money Follows the Person (MFP) grant. To determine the rate the transition data from MFP averaged 300 hours of transition coordination multiplied the current rate for case management services.

The rate methodology for cost-based rates under Fee for Service (FFS) waiver programs of Emergency Response Service, Home Delivered Meals, Nurse Educator and Adult Daycare to be paid at the reasonable and customary rate.

NMT escort rate is based on the average paid for a driver using their personal vehicle in ND according to the US Bureau of labor and statistics.

Adult foster care (AFC) & family personal care (FPC) QSP rate methodology on a daily cap, where rates are determined based on a formula and factor-based system. FPC to be based off hours worked up to a cap of 10 hours per day. The hourly rate for FPC is based on a blended rate of similar svc, (AFC).

Agency CM providers rates were initially established by a committee that was charged with establishing the rates based on the average salary being paid to social workers (SW) at that time & other information provided by CM entities. The unit rate is a monthly rate. The estimated number of units is 4 units per consumer per year. The rates have since been reviewed and increased based on LEG action.

Environmental modification (Env Mod) and specialized equipment (Sp Eq) costs are based on the actual cost of the modification or the cost of the equipment.

The average rate per unit for Residential Habilitation and Community Support is based on the actual cost per unit for the services in SFY 2026 and inflated by 3% based on historical annual rate increases granted to waiver providers by the legislature. The components are direct care staff employment related costs program supports & general & admin costs. SMA uses a FFS system where the budget for a service is based on the max number of hrs authorized for the client. Services are paid on a daily rate based on the number of hrs of daily service authorized for each client & the rates vary by client. The level on ongoing daily support will be determined by the assessed need from the HCBS assessment tool & person-centered planning. QSPs may only be reimbursed for the time spent providing habilitation to the client. The rates are uniform across all QSPs.

Rural Differential Rate allows the following services to be paid at a higher rate when they are provided to recipients who live in rural areas: RC, HMK, Ex-PC including nurse ed, chore, WPC & transitional living services, Transition Coordination, Supervision and companionship to attract QSP's. QSP who are willing to travel at least 21 miles round trip to provide care to waiver recipients in rural areas may be paid at a higher rate. Providers who are not traveling to rural areas to provide these services will continue to use the previous rate. The SMA has established 3 rate tiers based on the number of miles a provider travels round trip to provide care. Tier 1 covers (21-50 miles), Tier 2 (51-70 mi) & Tier 3 (71+ mi). Estimates for the higher rates were based on the mid-point mileage amount of each tier, multiplied by 27.75 cents per mile (1/2 of the GSA mileage Rate as of 4/12) and inflated by an average of 3% upon legislative approval thereafter.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

All providers of emergency response, family personal care, home delivered meals are required to complete requests for payments on an SFN 1730 HCBS billing form or use the web portal available in MMIS. All other providers will need to submit payment using the professional claim MMIS portal. Paper claims and those submitted via the web portal go directly from the provider to MMIS.
The state has chosen Therap LLC as the states EVV provider. The following waiver services are subject to EVV: homemaker, respite care, chore, companionship service, extended personal care, non-medical transportation, supervision, and transitional living.

All individual and agency QSPs who provide services subject to EVV have access to the Therap EVV system and the corresponding billing module free of charge. The Therap system uses EVV and other provider data to generate a professional claim via a billing module that can be submitted by the provider directly to MMIS. MMIS validates the professional claims data against all required edits and adjudicates the claim. Payments are sent directly to providers from MMIS.

ND has chosen an open EVV model that will also allow providers of the impacted services to use their own EVV system and submit data to an aggregator vendor contracted by the state. Individual and agency QSPs who have their own EVVS will submit a professional claim directly to MMIS via the web portal. MMIS validates the professional claims data against all required edits and adjudicates the claim. Payments are sent directly to providers from MMIS.

All service plans are reviewed and approved by Aging Services staff. The information from the service plan is used to create an authorization to provide services that is given to the provider before services begin. It lists the type, amount, duration, and frequency of the services the provider is authorized to provider to the participant. In addition, the information from the approved plan is used to create a pre-authorization (SA)in therap which is sent over to the MMIS system for all waiver services except for adult residential service and family personal care. The SA includes the type, amount, and duration of the services authorized. When claims are submitted the claims, data is checked against the SA for accuracy. If the claims are billed within the authorized limits it pays, if not, it denies. No SA is created for adult residential service and family personal care because MMIS contains other edits that prevent billing errors for these services.

Providers of impacted EVV services that choose to use Therap as their EVV system will receive a service authorization generated in the Therap system. Therap will share the SA with MMIS through the Sandata interface transaction for adjudication and validation of the claims information against the SA.

Case Managers have frequent contact with waiver recipients and are required to make a minimum of four quarterly visits each year. The visits include an assessment to determine if their service needs are being met. One of the quarterly visits is a quality review where the recipient is asked questions about the frequency and quality of their care to assure services are being rendered in the type, scope, amount, and frequency listed on the care plan. In addition, staff from Medical Services conduct provider reviews which include a review of billing records and provider documentation to assure services were rendered per the authorization to provide services.

If billing errors are found providers are notified of the issue in writing and adjustments are filed which create an accounts receivable in MMIS to recoup the funds. If a provider is closed or is not actively billing, they are asked to remit the payment ASAP. If they do not respond within the timeframe requested the matter is turned over to a collection agency.

All adjustments and corrections are reported on the CMS 64 report which reduces the State's federal reimbursement.

Participants or their legal representatives make an independent choice of provider. The case manager may assist a recipient in making an independent choice of provider by showing them a list of available providers and or helping them identify a friend, neighbor, etc. who may be interested in enrolling to provide the care. Participants or their legal representatives are required to indicate that they have made an independent choice on the plan of care.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Medicaid payment system will deny claims if the individual is not an approved Medicaid recipient. The State receives reports from Maximus. identifying individuals screened eligible for the waiver and the information including the eligibility period of the screening is entered into MMIS.

To assure proper claims payment, the Department conducts post payment audits to evaluate payments for accuracy, accountability and reasonableness. As part of the State's quality assurance efforts desk reviews of statistically valid number of HCBS waiver recipients paid claims data is reviewed to determine if activities and tasks were billed/paid within allowable limits.

Statistical significance of paid claims data will be determined by calculating a random representative sample of the total number of paid waiver claims for the previous waiver year (for example in waiver year 3 the State will use data from waiver year 2). The following parameters will be used 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution. The reviews are completed annually.

In addition to the representative sample of paid claims that will be calculated using the methodology described above, the State will also conduct annual on and off site reviews of a smaller sample (no less than 85) of provider files to determine if services are being provided according to policy and procedures and to determine if services are delivered by the type, scope, amount, duration and frequency specified in the service plan. These cases are not chosen randomly but are based on purposeful targeting of cases where billing irregularities have been found or when a case is especially complex. This includes an evaluation of the comprehensive assessment and the results are compared to the authorization to provide services and the clients service plan. The payment histories are cross-referenced with provider records. Inadequate records & inaccurate requests for payments are reported to the providers and findings & corrective actions are required.

In addition, the State Medicaid Agency performs audits of certain services that have been identified through discussion with HCBS and SURS team members to have a higher potential for inappropriate billing or other irregularities that warrant a review of claims data related to that service. A minimum of one targeted service audit is conducted annually.

If any of these reviews reveal payments that are in excess of what is authorized or unallowable they are recouped by the State. Recoupments are made through a provider adjustment or direct provider payment.

All service plans are reviewed & approved by Aging Services staff. The information from the service plan is used to create an authorization to provide services that is given to the provider before services begin. The preauth lists the type, amount, duration, and frequency of the services the provider is authorized to provider to the participant. The information from the approved plan is used to create a pre-auth in Therap which is sent to MMIS through the SA interface for all waiver services with the exception of adult residential care & family personal care. When claims are submitted the claims data is checked against the SA for accuracy through the SA interface. If the claims is billed within the authorized limits it pays, if not, it denies. No SA is created for ARS and FPC because MMIS contains other edits that prevent billing errors for these services.

Providers of impacted EVV services that choose to use Therap as their EVV system will receive a service authorization generated in the Therap system. Therap will share the SA with MMIS via a standard 278 transaction for adjudication and validation of the claims information against the SA.

Case Managers have frequent contact with waiver recipients and are required to make a minimum of four quarterly face to face visits each year. The visits include an assessment to determine if their service needs are being met. One of the quarterly visits is a quality review where the recipient is asked questions about the frequency & quality of their care to assure services are being rendered in the type, scope, amount, and frequency listed on the care plan. In addition staff from Medical Services conduct provider reviews which include a review of billing records and provider documentation to assure services were rendered per the authorization to provide services.

If billing errors are found providers are notified of the issue in writing and adjustments are filed which crate and accounts receivable in MMIS to recoup the funds. If a provider is closed or is not actively billing they are asked to remit the payment ASAP. If they do not respond within the timeframe requested the matter is turned over to a collection agency.

With the addition of EVVS the location, time & date of services rendered to ensure services were provided. In addition during the case management reviews State case management supervisors conduct home visits to assure the validity of

care.
The states Program integrity unity conducts program audits requiring providers to submit documentation to support claims payment & provide verification of the services & tasks provided during the visit.

All adjustments & corrections are reported on the CMS 64 report which reduces the State's federal reimbursement.

Participant's or their legal representatives make an independent choice of provider. The case manager may assist a recipient in making an independent choice of provider by showing them a list of available providers & or helping them identify a friend, neighbor etc. who may be interested in enrolling to provide the care. Participant's or their legal representatives are required to indicate that they have made an independent choice on the plan of care.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver*

services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

☑ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

- ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

North Dakota Department of Human Services-Aging Services Division provides regulatory Case Management and administratively claims for this service. Social Service Zones may enroll to provide Case Management/Care Coordination, Respite Care, Homemaker Service, Non-Medical Transportation, Chore Service, Supervision, Extended Personal Care, Community Transition Services, Residential Habilitation, Community Support and Companionship or provide services for which they are qualified to provide. North Dakota Indian Tribal entities may also enroll to provide services for which they are qualified to provide and choose to provide.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☑ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*
- ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Provider agency cost reports separately identify the costs of room and board. The room and board expenses are not included when determining the provider rate. Providers of service are responsible for collecting room and board directly from the client.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	54701.65	22972.01	77673.66	147829.80	144176.16	292005.96	214332.30
2	51363.20	23821.97	75185.17	153299.50	149510.68	302810.18	227625.01
3	48263.29	24703.39	72966.68	158971.58	155042.57	314014.15	241047.47
4	45393.77	25617.41	71011.18	164853.53	160779.15	325632.68	254621.50
5	42727.07	26565.26	69292.33	170953.11	166727.98	337681.09	268388.76

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	1559	1559
Year 2	1793	1793
Year 3	2062	2062
Year 4	2371	2372
Year 5	2727	2727

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay was calculated by using an average of the length of stay data reported on the last three (2024-2026) CMS 372 reports. This report shows the total number of days of waiver coverage for the home and community based services waiver. The report also shows the unduplicated count of recipients during that period of time. The average length of stay calculated from the reports is 257 days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Waiver renewal application effective 4.1.27 adjusted the Factor D Derivation of estimates for the estimated number of users, and average units per user based on actual data from state fiscal year (SFY) 2026. These adjustments were needed due to unprecedented growth in waiver participants from SFY 2021 to SFY 2026, the implementation of the services of Residential Habilitation, Community Support and Waiver Personal Care and the SMA administratively claiming for regulatory case management. These changes resulted in significant change in the estimates compared to actual data, requiring the SMA to adjust the estimated number of users and average units per user based on the actual utilization and expenditures. The SMA estimated the growth for Factor D is based on the average historical growth based on actuals from SFY 2026. The actuals from SFY 2026 were compared to preliminary data for the WY4 4/1/2025-3/31/2026, 372 report, and the 372 reports from WY 1, 2 and 3 which showed the need to make these adjustments to be based on actuals and inflated based on historical growth and legislatively approved increases.

Number of Estimated Users
The number of users estimated for waiver year (WY) 1 is based off a combination of various data sources including, CMS 372 reports for 4/1/2024-3/31/2025, and actual data from state fiscal year SFY 2026. The data from SFY 2026 shows actual utilization for waiver services and was inflated by the historical growth of waiver users of 4% for each waiver year (WY1 through WY5) excluding the unprecedented growth between SFY 2021 and SFY 2026 as the extraordinary increase in new waiver users appears to have stabilized.

Estimated average units per user
The estimated average units per user is based off a combination of various data sources including, CMS 372 reports for 4/1/2024-3/31/2025, and actual data from state fiscal year SFY 2026. The data from SFY 2026 shows actual current utilization for waiver services and was inflated by modest historical growth of waiver users of 1% for each waiver year (WY1 through WY5) excluding the unprecedented growth between SFY 2021 and SFY 2026 as the extraordinary increase in new waiver users appears to have stabilized.

Average Cost Per Unit:
The average cost per unit was calculated by using the current average rate paid for each service inflated by 3% each year. 3% is based on historical annual rate increases granted to waiver providers by the legislature.

Waiver personal care, homemaker, supervision, respite care, chore, companionship services, non-medical transportation, extended personal care/nurse education and non-rural differential rates are a blended average of the agency and individual current fee for service rates paid for each service. The average RD rates for these services were calculated in the same way but an average of the agency and individual current fee for service RD rates paid for each service was used. The state utilized data from SFY 2026 to provide utilization data for services.

Transitional Living service can only be provided by an agency and therefore the cost per unit is based on the current agency rate. The average RD rate for this service was calculated in the same way but an average of the agency RD rate was used.

Adult day care, adult residential services, adult foster care, emergency response, environmental modification, family personal care and specialized equipment and supplies were calculated using an average of all of the rates paid for each service. The list of rates is maintained by the State Medicaid Agency. This method was used because the rates for these services are unique to each provider or client.

Agency case management costs per unit were determined by calculating an average of the current annual agency assessment rate and the current agency case management rate paid for all other agency case management contacts historically as there are no current providers for this service.

Community transition services was calculated based on historical data of the number of units multiplied by the rate of the transitions from nursing facilities under the Money Follows the Person (MFP) grant. To determine the rate the transition data from MFP averaged 300 hours of transition coordination multiplied the current rate for case management services.

The average cost per unit for Residential Habilitation and Community Support is based on the actual cost per unit for the services in SFY 2026 and inflated by 3% based on historical annual rate increases granted to waiver

providers by the legislature.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The 372 report for 04/01/2024 to 03/31/2025 for the HCBS waiver indicates that the estimated cost of all other services paid on behalf of waiver recipients averaged $22972. This does not include cost of prescribed drugs that are furnished to Medicare/ Medicaid eligible individuals under Part D. For WY1-WY5 this figure was inflated by 3.7% based on the current medical Consumer Price Index (CPI).

D' is based on the most recent 372 report for this waiver and G' was based on the Department's fiscal spend-down report so both sources use actual expenditure data. Nursing home recipients may use more "other" Medicaid services because their conditions may be less stable or, because they are receiving services in a medical model where referral for additional healthcare services might be more common. "Other" Medicaid services include inpatient and outpatient hospital services, physician services and dental services.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

A state generated financial report was used to calculate the G factor. The G factor is based on the current average cost for nursing facility services for those individuals eligible for the HCBS waiver minus the average nursing home recipient liability (cost share). This amount was inflated by 3.7% for WY 1 -5 based on the 2026 consumer price index for nursing homes and Adult Day services.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

A state generated financial report was used to calculate G', the average cost of "other" Medicaid services. This figure does not include the cost of prescribed drugs furnished to dual eligible under Medicare Part D. This amount was inflated by 3.7% for WY1-WY5 based on the current medical Consumer Price Index (CPI).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.*

Waiver Services	
Adult Day Care	
Adult Residential Care	
HCBS Care Coordination	
Homemaker	
Residential Habilitation	
Respite Care	
Supported Employment	
Waiver Personal Care	
Adult Foster Care	
Chore	
Community Support Service	
Community Transition Services	
Companionship Service	
Emergency Response	
Environmental Modification	

Waiver Services	
Extended Personal Care	
Family Personal Care	
Home Delivered Meals	
Non-Medical Transportation	
Specialized Equipment & Supplies	
Supervision	
Transitional Living	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Care Total:						***9227.38***
Adult Day Care	*1/2 day*	*1*	*181.00*	*50.98*	***9227.38***	
Adult Residential Care Total:						***9673587.00***
Adult Residential Care	*Daily*	*225*	*252.00*	*170.61*	***9673587.00***	
HCBS Care Coordination Total:						***9690.00***
Agency Case Management	*Monthly*	*10*	*4.00*	*242.25*	***9690.00***	
Homemaker Total:						***141219.72***
Homemaker	*15 min.*	*49*	*229.00*	*8.81*	***98857.01***	
Rural Differential Tier 1	*15 min.*	*4*	*229.00*	*11.41*	***10451.56***	
Rural Differential Tier 2	*15 min.*	*5*	*229.00*	*13.25*	***15171.25***	
Rural Differential Tier 3	*15 min.*	*5*	*229.00*	*14.62*	***16739.90***	
Residential Habilitation Total:						***5220100.20***
Residential Habilitation	*Daily*	*30*	*302.00*	*576.17*	***5220100.20***	
Respite Care Total:						***651608.37***

GRAND TOTAL: 85279877.48

Total Estimated Unduplicated Participants: 1559

Factor D (Divide total by number of participants): 54701.65

Average Length of Stay on the Waiver: *257*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care	15 min.	53	973.00	8.81	454322.89	
Rural Differential Tier 1	15 min.	8	973.00	11.41	88815.44	
Rural Differential Tier 2	15 min.	4	973.00	13.25	51569.00	
Rural Differential Tier 3	15 min.	4	973.00	14.62	56901.04	
Supported Employment Total:						33048.00
Supported Employment	15 min.	5	648.00	10.20	33048.00	
Waiver Personal Care Total:						23413377.00
Daily Waiver Personal Care	15 min	10	359.00	120.46	432451.40	
Waiver Personal Care	15 min	175	14155.00	8.81	21823471.25	
Waiver Personal Care Rural Differential Tier 1	15 min	1	14155.00	11.41	161508.55	
Waiver Personal Care Rural Differential Tier 2	15 min	2	14155.00	13.25	375107.50	
Waiver Personal Care Rural Differential Tier 3	15 min	3	14155.00	14.62	620838.30	
Adult Foster Care Total:						137335.68
Adult Foster Care	Daily	4	211.00	162.72	137335.68	
Chore Total:						19873.28
Chore	15 min.	31	56.00	8.81	15294.16	
Chore Rural Differential Tier 1	15 min.	1	56.00	11.41	638.96	
Chore Rural Differential Tier 2	15 min.	2	56.00	13.25	1484.00	
Chore Rural Differential Tier 3	15 min.	3	56.00	14.62	2456.16	
Community Support Service Total:						31740820.16
Community Support Service	Daily	196	232.00	698.03	31740820.16	
Community Transition Services Total:						84652.40
One-Time Transition Cost	Per Item	4	1.00	3000.00	12000.00	

GRAND TOTAL: 85279877.48

Total Estimated Unduplicated Participants: 1559

Factor D (Divide total by number of participants): 54701.65

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Coordination	15 min	1	1060.00	14.11	14956.60	
Transition Coordination Rural Differential Tier 1	15 min	1	1060.00	16.57	17564.20	
Transition Coordination Rural Differential Tier 2	15 min.	1	1060.00	18.28	19376.80	
Transition Coordination Rural Differential Tier 3	15 min	1	1060.00	19.58	20754.80	
Companionship Service Total:						136327.26
Companionship Service	15 min.	79	174.00	8.54	117390.84	
Companionship Service Rural Differential Tier 1	15 min	1	174.00	11.14	1938.36	
Companionship Service Rural Differential Tier 2	15 min	2	174.00	12.97	4513.56	
Companionship Service Rural Differential Tier 3	15 min.	5	174.00	14.35	12484.50	
Emergency Response Total:						115803.68
Emergency Response	Monthly	254	8.00	56.99	115803.68	
Environmental Modification Total:						69382.39
Environmental Modification	Per Job	11	1.00	6307.49	69382.39	
Extended Personal Care Total:						578037.06
Extended Personal Care	15 min.	83	679.00	8.81	496505.17	
Extended Personal Care Rural Differential Tier 1	15 min.	1	679.00	11.41	7747.39	
Extended Personal Care Rural Differential Tier 2	15 min.	2	679.00	13.25	17993.50	
Extended Personal Care Rural Differential Tier 3	15 min.	2	679.00	14.62	19853.96	
Nurse Education	15 min.	67	23.00	21.38	32946.58	
Nurse Education Rural Differential Tier 1	15 min.	1	23.00	23.98	551.54	
Nurse Education Rural Differential Tier 2	15 min.	2	23.00	25.82	1187.72	
Extended Personal					1251.20	

GRAND TOTAL: 85279877.48

Total Estimated Unduplicated Participants: 1559

Factor D (Divide total by number of participants): 54701.65

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Rural Differential Tier 3	15 min.	2	23.00	27.20		
Family Personal Care Total:						**10779460.56**
Family Personal Care	Daily	216	297.00	168.03	**10779460.56**	
Home Delivered Meals Total:						**368271.36**
Home Delivered Meals	Per Meal	144	216.00	11.84	**368271.36**	
Non-Medical Transportation Total:						**170868.32**
Non-Medical Transportation	15 min	122	164.00	8.54	**170868.32**	
Specialized Equipment & Supplies Total:						**12411.00**
Specialized Equipment & Supplies	Per Item	3	1.00	4137.00	**12411.00**	
Supervision Total:						**1262460.62**
Supervision	15 min.	24	4663.00	8.54	**955728.48**	
Supervision Rural Differential Tier 1	15 min	1	4663.00	11.14	**51945.82**	
Supervision Rural Differential Tier 2	15 min	2	4663.00	12.97	**120958.22**	
Supervision Rural Differential Tier 3	15 min.	2	4663.00	14.35	**133828.10**	
Transitional Living Total:						**652316.04**
Transitional Living	15 min.	1	12161.00	10.20	**124042.20**	
Transitional Living Rural Differential Tier 1	15 min.	1	12161.00	12.80	**155660.80**	
Transitional Living Rural Differential Tier 2	15 min.	1	12161.00	14.63	**177915.43**	
Transitional Living Rural Differential Tier 3	15 min.	1	12161.00	16.01	**194697.61**	

GRAND TOTAL: 85279877.48

Total Estimated Unduplicated Participants: 1559

Factor D (Divide total by number of participants): 54701.65

Average Length of Stay on the Waiver: 257

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be*

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**9609.33**
Adult Day Care	1/2 day	1	183.00	52.51	**9609.33**	
Adult Residential Care Total:						**10485809.10**
Adult Residential Care	Daily	234	255.00	175.73	**10485809.10**	
HCBS Care Coordination Total:						**9980.80**
Agency Case Management	Monthly	10	4.00	249.52	**9980.80**	
Homemaker Total:						**150859.17**
Homemaker	15 min.	51	231.00	9.07	**106853.67**	
Rural Differential Tier 1	15 min.	4	231.00	11.75	**10857.00**	
Rural Differential Tier 2	15 min.	5	231.00	13.64	**15754.20**	
Rural Differential Tier 3	15 min.	5	231.00	15.06	**17394.30**	
Residential Habilitation Total:						**5611069.75**
Residential Habilitation	Daily	31	305.00	593.45	**5611069.75**	
Respite Care Total:						**695619.95**
Respite Care	15 min.	55	983.00	9.07	**490369.55**	
Rural Differential Tier 1	15 min.	8	983.00	11.75	**92402.00**	
Rural Differential Tier 2	15 min.	4	983.00	13.64	**53632.48**	
Rural Differential Tier 3	15 min.	4	983.00	15.06	**59215.92**	
Supported Employment Total:						**34335.00**
Supported Employment	15 min.	5	654.00	10.50	**34335.00**	
Waiver Personal Care Total:						**25249991.45**
Daily Waiver Personal Care	Daily	10	359.00	124.07	**445411.30**	
Waiver Personal					**23600629.78**	

GRAND TOTAL: 92094214.59

Total Estimated Unduplicated Participants: 1793

Factor D (Divide total by number of participants): 51363.20

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care	15 min	182	14297.00	9.07		
Waiver Personal Care Rural Differential Tier 1	15 min	1	14297.00	11.75	167989.75	
Waiver Personal Care Rural Differential Tier 2	15 min	2	14297.00	13.64	390022.16	
Waiver Personal Care Rural Differential Tier 3	15 min	3	14297.00	15.06	645938.46	
Adult Foster Care Total:						142795.20
Adult Foster Care	Daily	4	213.00	167.60	142795.20	
Chore Total:						21343.65
Chore	15 min.	32	57.00	9.07	16543.68	
Chore Rural Differential Tier 1	15 min.	1	57.00	11.75	669.75	
Chore Rural Differential Tier 2	15 min.	2	57.00	13.64	1554.96	
Chore Rural Differential Tier 3	15 min.	3	57.00	15.06	2575.26	
Community Support Service Total:						34320751.92
Community Support Service	Daily	204	234.00	718.97	34320751.92	
Community Transition Services Total:						87066.39
One-Time Transition Cost	Per Item	4	1.00	3000.00	12000.00	
Transition Coordination	15 min	1	1071.00	14.43	15454.53	
Transition Coordination Rural Differential Tier 1	15 min	1	1071.00	16.95	18153.45	
Transition Coordination Rural Differential Tier 2	15 min.	1	1071.00	18.69	20016.99	
Transition Coordination Rural Differential Tier 3	15 min	1	1071.00	20.02	21441.42	
Companionship Service Total:						146585.12
Companionship Service	15 min.	82	176.00	8.79	126857.28	
Companionship Service Rural Differential Tier 1	15 min	1	176.00	11.47	2018.72	
Companionship					4702.72	

GRAND TOTAL: 92094214.59

Total Estimated Unduplicated Participants: 1793

Factor D (Divide total by number of participants): 51363.20

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service Rural Differential Tier 2	15 min	2	176.00	13.36		
Companionship Service Rural Differential Tier 3	15 min.	5	176.00	14.78	13006.40	
Emergency Response Total:						123974.40
Emergency Response	Monthly	264	8.00	58.70	123974.40	
Environmental Modification Total:						71463.81
Environmental Modification	Per Job	11	1.00	6496.71	71463.81	
Extended Personal Care Total:						621062.52
Extended Personal Care	15 min.	86	686.00	9.07	535093.72	
Extended Personal Care Rural Differential Tier 1	15 min.	1	686.00	11.75	8060.50	
Extended Personal Care Rural Differential Tier 2	15 min.	2	686.00	13.64	18714.08	
Extended Personal Care Rural Differential Tier 3	15 min.	2	686.00	15.06	20662.32	
Nurse Education	15 min.	70	23.00	22.02	35452.20	
Nurse Education Rural Differential Tier 1	15 min.	1	23.00	24.70	568.10	
Nurse Education Rural Differential Tier 2	15 min.	2	23.00	26.59	1223.14	
Extended Personal Care Rural Differential Tier 3	15 min.	2	23.00	28.01	1288.46	
Family Personal Care Total:						11682225.00
Family Personal Care	Daily	225	300.00	173.07	11682225.00	
Home Delivered Meals Total:						398940.00
Home Delivered Meals	Per Meal	150	218.00	12.20	398940.00	
Non-Medical Transportation Total:						185310.78
Non-Medical Transportation	15 min.	127	166.00	8.79	185310.78	
Specialized Equipment & Supplies Total:						12783.33
Specialized Equipment &	Per Item		1.00	4261.11	12783.33	

GRAND TOTAL: 92094214.59

Total Estimated Unduplicated Participants: 1793

Factor D (Divide total by number of participants): 51363.20

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supplies		3				
Supervision Total:						**1354125.00**
Supervision	15 min.	25	4710.00	8.79	**1035022.50**	
Supervision Rural Differential Tier 1	15 min	1	4710.00	11.47	**54023.70**	
Supervision Rural Differential Tier 2	15 min	2	4710.00	13.36	**125851.20**	
Supervision Rural Differential Tier 3	15 min.	2	4710.00	14.78	**139227.60**	
Transitional Living Total:						**678512.92**
Transitional Living	15 min.	1	12283.00	10.50	**128971.50**	
Transitional Living Rural Differential Tier 1	15 min.	1	12283.00	13.18	**161889.94**	
Transitional Living Rural Differential Tier 2	15 min.	1	12283.00	15.07	**185104.81**	
Transitional Living Rural Differential Tier 3	15 min.	1	12283.00	16.49	**202546.67**	

GRAND TOTAL: 92094214.59
Total Estimated Unduplicated Participants: 1793
Factor D (Divide total by number of participants): 51363.20
Average Length of Stay on the Waiver: 257

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**9952.56**
Adult Day Care	1/2 day	1	184.00	54.09	**9952.56**	
Adult Residential Care Total:						**11303631.00**
Adult Residential					**11303631.00**	

GRAND TOTAL: 99518906.40
Total Estimated Unduplicated Participants: 2062
Factor D (Divide total by number of participants): 48263.29
Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care	Daily	243	257.00	181.00		
HCBS Care Coordination Total:						**11308.00**
Agency Case Management	Monthly	11	4.00	257.00	**11308.00**	
Homemaker Total:						**161754.84**
Homemaker	15 min.	53	234.00	9.34	**115834.68**	
Rural Differential Tier 1	15 min.	4	234.00	12.11	**11334.96**	
Rural Differential Tier 2	15 min.	5	234.00	14.05	**16438.50**	
Rural Differential Tier 3	15 min.	5	234.00	15.51	**18146.70**	
Residential Habilitation Total:						**6024578.56**
Residential Habilitation	Daily	32	308.00	611.26	**6024578.56**	
Respite Care Total:						**754292.73**
Respite Care	15 min.	57	993.00	9.34	**528653.34**	
Rural Differential Tier 1	15 min.	9	993.00	12.11	**108227.07**	
Rural Differential Tier 2	15 min.	4	993.00	14.05	**55806.60**	
Rural Differential Tier 3	15 min.	4	993.00	15.51	**61605.72**	
Supported Employment Total:						**35760.10**
Supported Employment	15 min.	5	661.00	10.82	**35760.10**	
Waiver Personal Care Total:						**27247522.71**
Daily Waiver Personal Care	Daily	11	359.00	127.79	**504642.71**	
Waiver Personal Care	15 min	189	14440.00	9.34	**25490354.40**	
Waiver Personal Care Rural Differential Tier 1	15 min	1	14440.00	12.11	**174868.40**	
Waiver Personal Care Rural Differential Tier 2	15 min	2	14440.00	14.05	**405764.00**	
Waiver Personal Care Rural Differential Tier 3	15 min	3	14440.00	15.51	**671893.20**	
Adult Foster Care						**148453.20**

GRAND TOTAL: 99518906.40

Total Estimated Unduplicated Participants: 2062

Factor D (Divide total by number of participants): 48263.29

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Adult Foster Care	Daily	4	215.00	172.62	**148453.20**	
Chore Total:						**23045.10**
Chore	15 min.	34	57.00	9.34	**18100.92**	
Chore Rural Differential Tier 1	15 min.	1	57.00	12.11	**690.27**	
Chore Rural Differential Tier 2	15 min.	2	57.00	14.05	**1601.70**	
Chore Rural Differential Tier 3	15 min.	3	57.00	15.51	**2652.21**	
Community Support Service Total:						**37207691.76**
Community Support Service	Daily	212	237.00	740.54	**37207691.76**	
Community Transition Services Total:						**90098.76**
One-Time Transition Cost	Per Item	4	1.00	3000.00	**12000.00**	
Transition Coordination	15 min	1	1082.00	14.86	**16078.52**	
Transition Coordination Rural Differential Tier 1	15 min	1	1082.00	17.45	**18880.90**	
Transition Coordination Rural Differential Tier 2	15 min.	1	1082.00	19.25	**20828.50**	
Transition Coordination Rural Differential Tier 3	15 min	1	1082.00	20.62	**22310.84**	
Companionship Service Total:						**156749.43**
Companionship Service	15 min.	85	177.00	9.06	**136307.70**	
Companionship Service Rural Differential Tier 1	15 min	1	177.00	11.82	**2092.14**	
Companionship Service Rural Differential Tier 2	15 min	2	177.00	13.76	**4871.04**	
Companionship Service Rural Differential Tier 3	15 min.	5	177.00	15.23	**13478.55**	
Emergency Response Total:						**149638.50**
Emergency Response	Monthly	275	9.00	60.46	**149638.50**	
Environmental Modification Total:						**80299.44**

GRAND TOTAL: 99518906.40

Total Estimated Unduplicated Participants: 2062

Factor D (Divide total by number of participants): 48263.29

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification	Per Job	12	1.00	6691.62	80299.44	
Extended Personal Care Total:						672628.43
Extended Personal Care	15 min.	90	693.00	9.34	582535.80	
Extended Personal Care Rural Differential Tier 1	15 min.	1	693.00	12.11	8392.23	
Extended Personal Care Rural Differential Tier 2	15 min.	2	693.00	14.05	19473.30	
Extended Personal Care Rural Differential Tier 3	15 min.	2	693.00	15.51	21496.86	
Nurse Education	15 min.	72	23.00	22.68	37558.08	
Nurse Education Rural Differential Tier 1	15 min.	1	23.00	25.44	585.12	
Nurse Education Rural Differential Tier 2	15 min.	2	23.00	27.39	1259.94	
Extended Personal Care Rural Differential Tier 3	15 min.	2	23.00	28.85	1327.10	
Family Personal Care Total:						12638990.52
Family Personal Care	Daily	234	303.00	178.26	12638990.52	
Home Delivered Meals Total:						431059.20
Home Delivered Meals	Per Meal	156	220.00	12.56	431059.20	
Non-Medical Transportation Total:						199718.64
Non-Medical Transportation	15 min	132	167.00	9.06	199718.64	
Specialized Equipment & Supplies Total:						13166.85
Specialized Equipment & Supplies	Per Item	3	1.00	4388.95	13166.85	
Supervision Total:						1452597.52
Supervision	15 min.	26	4757.00	9.06	1120558.92	
Supervision Rural Differential Tier 1	15 min	1	4757.00	11.82	56227.74	
Supervision Rural Differential Tier 2	15 min	2	4757.00	13.76	130912.64	
Supervision Rural					144898.22	

GRAND TOTAL: 99518906.40

Total Estimated Unduplicated Participants: 2062

Factor D (Divide total by number of participants): 48263.29

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Differential Tier 3	15 min.	2	4757.00	15.23		
Transitional Living Total:						**705968.55**
Transitional Living	15 min.	1	12405.00	10.82	**134222.10**	
Transitional Living Rural Differential Tier 1	15 min.	1	12405.00	13.58	**168459.90**	
Transitional Living Rural Differential Tier 2	15 min.	1	12405.00	15.52	**192525.60**	
Transitional Living Rural Differential Tier 3	15 min.	1	12405.00	16.99	**210760.95**	

GRAND TOTAL: 99518906.40
Total Estimated Unduplicated Participants: 2062
Factor D (Divide total by number of participants): 48263.29
Average Length of Stay on the Waiver: 257

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**10362.06**
Adult Day Care	1/2 day	1	186.00	55.71	**10362.06**	
Adult Residential Care Total:						**12263365.40**
Adult Residential Care	Daily	253	260.00	186.43	**12263365.40**	
HCBS Care Coordination Total:						**11647.24**
Agency Case Management	Monthly	11	4.00	264.71	**11647.24**	
Homemaker Total:						**179886.28**
Homemaker	15 min.	55	236.00	9.63	**124997.40**	
Rural Differential					**11771.68**	

GRAND TOTAL: 107628631.30
Total Estimated Unduplicated Participants: 2371
Factor D (Divide total by number of participants): 45393.77
Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier 1	15 min.	4	236.00	12.47		
Rural Differential Tier 2	15 min.	6	236.00	14.47	20489.52	
Rural Differential Tier 3	15 min.	6	236.00	15.98	22627.68	
Residential Habilitation Total:						6657284.66
Residential Habilitation	Daily	34	311.00	629.59	6657284.66	
Respite Care Total:						813453.66
Respite Care	15 min.	60	1002.00	9.63	578955.60	
Rural Differential Tier 1	15 min.	9	1002.00	12.47	112454.46	
Rural Differential Tier 2	15 min.	4	1002.00	14.47	57995.76	
Rural Differential Tier 3	15 min.	4	1002.00	15.98	64047.84	
Supported Employment Total:						44649.12
Supported Employment	15 min.	6	668.00	11.14	44649.12	
Waiver Personal Care Total:						29490339.51
Daily Waiver Personal Care	Daily	11	359.00	131.63	519806.87	
Waiver Personal Care	15 min	197	14584.00	9.63	27667452.24	
Waiver Personal Care Rural Differential Tier 1	15 min	1	14584.00	12.47	181862.48	
Waiver Personal Care Rural Differential Tier 2	15 min	2	14584.00	14.47	422060.96	
Waiver Personal Care Rural Differential Tier 3	15 min	3	14584.00	15.98	699156.96	
Adult Foster Care Total:						154330.40
Adult Foster Care	Daily	4	217.00	177.80	154330.40	
Chore Total:						24731.20
Chore	15 min.	35	58.00	9.63	19548.90	
Chore Rural Differential Tier 1	15 min.	1	58.00	12.47	723.26	
Chore Rural					1678.52	

GRAND TOTAL: 107628631.30

Total Estimated Unduplicated Participants: 2371

Factor D (Divide total by number of participants): 45393.77

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Differential Tier 2	15 min.	2	58.00	14.47		
Chore Rural Differential Tier 3	15 min.	3	58.00	15.98	2780.52	
Community Support Service Total:						40105920.80
Community Support Service	Daily	220	239.00	762.76	40105920.80	
Community Transition Services Total:						93275.48
One-Time Transition Cost	Per Item	4	1.00	3000.00	12000.00	
Transition Coordination	15 min	1	1093.00	15.31	16733.83	
Transition Coordination Rural Differential Tier 1	15 min	1	1093.00	17.98	19652.14	
Transition Coordination Rural Differential Tier 2	15 min.	1	1093.00	19.83	21674.19	
Transition Coordination Rural Differential Tier 3	15 min	1	1093.00	21.24	23215.32	
Companionship Service Total:						172731.42
Companionship Service	15 min.	89	179.00	9.33	148636.23	
Companionship Service Rural Differential Tier 1	15 min	1	179.00	12.17	2178.43	
Companionship Service Rural Differential Tier 2	15 min	2	179.00	14.18	5076.44	
Companionship Service Rural Differential Tier 3	15 min.	6	179.00	15.68	16840.32	
Emergency Response Total:						160308.72
Emergency Response	Monthly	286	9.00	62.28	160308.72	
Environmental Modification Total:						82708.32
Environmental Modification	Per Job	12	1.00	6892.36	82708.32	
Extended Personal Care Total:						723729.68
Extended Personal Care	15 min.	93	700.00	9.63	626913.00	
Extended Personal Care Rural Differential Tier 1	15 min.	1	700.00	12.47	8729.00	
Extended Personal Care Rural					20258.00	

GRAND TOTAL: 107628631.30

Total Estimated Unduplicated Participants: 2371

Factor D (Divide total by number of participants): 45393.77

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Differential Tier 2	15 min.	2	700.00	14.47		
Extended Personal Care Rural Differential Tier 3	15 min.	2	700.00	15.98	22372.00	
Nurse Education	15 min.	75	24.00	23.36	42048.00	
Nurse Education Rural Differential Tier 1	15 min.	1	24.00	26.21	629.04	
Nurse Education Rural Differential Tier 2	15 min.	2	24.00	28.21	1354.08	
Extended Personal Care Rural Differential Tier 3	15 min.	2	24.00	29.72	1426.56	
Family Personal Care Total:						13652872.38
Family Personal Care	Daily	243	306.00	183.61	13652872.38	
Home Delivered Meals Total:						467470.44
Home Delivered Meals	Per Meal	162	223.00	12.94	467470.44	
Non-Medical Transportation Total:						216017.49
Non-Medical Transportation	15 min	137	169.00	9.33	216017.49	
Specialized Equipment & Supplies Total:						13561.86
Specialized Equipment & Supplies	Per Item	3	1.00	4520.62	13561.86	
Supervision Total:						1555535.20
Supervision	15 min.	27	4804.00	9.33	1210175.64	
Supervision Rural Differential Tier 1	15 min	1	4804.00	12.17	58464.68	
Supervision Rural Differential Tier 2	15 min	2	4804.00	14.18	136241.44	
Supervision Rural Differential Tier 3	15 min.	2	4804.00	15.68	150653.44	
Transitional Living Total:						734449.98
Transitional Living	15 min.	1	12529.00	11.14	139573.06	
Transitional Living Rural Differential Tier 1	15 min.	1	12529.00	13.99	175280.71	
Transitional Living Rural Differential	15 min.	1	12529.00	15.99	200338.71	

GRAND TOTAL: 107628631.30

Total Estimated Unduplicated Participants: 2371

Factor D (Divide total by number of participants): 45393.77

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier 2						
Transitional Living Rural Differential Tier 3	15 min.	1	12529.00	17.50	219257.50	

GRAND TOTAL: 107628631.30
Total Estimated Unduplicated Participants: 2371
Factor D (Divide total by number of participants): 45393.77
Average Length of Stay on the Waiver: 257

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						10787.44
Adult Day Care	1/2 day	1	188.00	57.38	10787.44	
Adult Residential Care Total:						13231330.12
Adult Residential Care	Daily	263	262.00	192.02	13231330.12	
HCBS Care Coordination Total:						13087.68
Agency Case Management	Monthly	12	4.00	272.66	13087.68	
Homemaker Total:						194515.02
Homemaker	15 min.	57	238.00	9.91	134439.06	
Rural Differential Tier 1	15 min.	5	238.00	12.84	15279.60	
Rural Differential Tier 2	15 min.	6	238.00	14.91	21291.48	
Rural Differential Tier 3	15 min.	6	238.00	16.46	23504.88	
Residential Habilitation Total:						7126795.20
Residential Habilitation	Daily	35	314.00	648.48	7126795.20	

GRAND TOTAL: 116516719.37
Total Estimated Unduplicated Participants: 2727
Factor D (Divide total by number of participants): 42727.07
Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						**898358.79**
Respite Care	15 min.	62	1013.00	9.91	**622407.46**	
Rural Differential Tier 1	15 min.	9	1013.00	12.84	**117062.28**	
Rural Differential Tier 2	15 min.	5	1013.00	14.91	**75519.15**	
Rural Differential Tier 3	15 min.	5	1013.00	16.46	**83369.90**	
Supported Employment Total:						**46425.12**
Supported Employment	15 min.	6	674.00	11.48	**46425.12**	
Waiver Personal Care Total:						**32107015.14**
Daily Waiver Personal Care	Daily	12	359.00	135.58	**584078.64**	
Waiver Personal Care	15 min	205	14730.00	9.91	**29924731.50**	
Waiver Personal Care Rural Differential Tier 1	15 min	1	14730.00	12.84	**189133.20**	
Waiver Personal Care Rural Differential Tier 2	15 min	2	14730.00	14.91	**439248.60**	
Waiver Personal Care Rural Differential Tier 3	15 min	4	14730.00	16.46	**969823.20**	
Adult Foster Care Total:						**201454.00**
Adult Foster Care	Daily	5	220.00	183.14	**201454.00**	
Chore Total:						**26985.08**
Chore	15 min.	36	58.00	9.91	**20692.08**	
Chore Rural Differential Tier 1	15 min.	1	58.00	12.84	**744.72**	
Chore Rural Differential Tier 2	15 min.	2	58.00	14.91	**1729.56**	
Chore Rural Differential Tier 3	15 min.	4	58.00	16.46	**3818.72**	
Community Support Service Total:						**43358685.96**
Community Support Service	Daily	229	241.00	785.64	**43358685.96**	
Community Transition Services Total:						**99566.40**
One-Time					**15000.00**	

GRAND TOTAL: 116516719.37

Total Estimated Unduplicated Participants: 2727

Factor D (Divide total by number of participants): 42727.07

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Cost	Per Item	5	1.00	3000.00		
Transition Coordination	15 min	1	1104.00	15.77	17410.08	
Transition Coordination Rural Differential Tier 1	15 min	1	1104.00	18.52	20446.08	
Transition Coordination Rural Differential Tier 2	15 min.	1	1104.00	20.43	22554.72	
Transition Coordination Rural Differential Tier 3	15 min	1	1104.00	21.88	24155.52	
Companionship Service Total:						185119.56
Companionship Service	15 min.	92	181.00	9.61	160025.72	
Companionship Service Rural Differential Tier 1	15 min	1	181.00	12.54	2269.74	
Companionship Service Rural Differential Tier 2	15 min	2	181.00	14.60	5285.20	
Companionship Service Rural Differential Tier 3	15 min.	6	181.00	16.15	17538.90	
Emergency Response Total:						171446.22
Emergency Response	Monthly	297	9.00	64.14	171446.22	
Environmental Modification Total:						92288.82
Environmental Modification	Per Job	13	1.00	7099.14	92288.82	
Extended Personal Care Total:						781605.19
Extended Personal Care	15 min.	97	707.00	9.91	679617.89	
Extended Personal Care Rural Differential Tier 1	15 min.	1	707.00	12.84	9077.88	
Extended Personal Care Rural Differential Tier 2	15 min.	2	707.00	14.91	21082.74	
Extended Personal Care Rural Differential Tier 3	15 min.	2	707.00	16.46	23274.44	
Nurse Education	15 Min.	78	24.00	24.06	45040.32	
Nurse Education Rural Differential Tier 1	15 min.	1	24.00	26.99	647.76	
Nurse Education Rural Differential	15 min.	2	24.00	29.06	1394.88	

GRAND TOTAL: 116516719.37

Total Estimated Unduplicated Participants: 2727

Factor D (Divide total by number of participants): 42727.07

Average Length of Stay on the Waiver: 257

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier 2						
Extended Personal Care Rural Differential Tier 3	15 min.	2	24.00	30.61	1469.28	
Family Personal Care Total:						14784834.24
Family Personal Care	Daily	253	309.00	189.12	14784834.24	
Home Delivered Meals Total:						503874.00
Home Delivered Meals	Per Meal	168	225.00	13.33	503874.00	
Non-Medical Transportation Total:						234993.33
Non-Medical Transportation	15 min	143	171.00	9.61	234993.33	
Specialized Equipment & Supplies Total:						18624.92
Specialized Equipment & Supplies	Per Item	4	1.00	4656.23	18624.92	
Supervision Total:						1664818.24
Supervision	15 min.	28	4852.00	9.61	1305576.16	
Supervision Rural Differential Tier 1	15 min	1	4852.00	12.54	60844.08	
Supervision Rural Differential Tier 2	15 min	2	4852.00	14.60	141678.40	
Supervision Rural Differential Tier 3	15 min.	2	4852.00	16.15	156719.60	
Transitional Living Total:						764108.90
Transitional Living	15 min.	1	12655.00	11.48	145279.40	
Transitional Living Rural Differential Tier 1	15 min.	1	12655.00	14.41	182358.55	
Transitional Living Rural Differential Tier 2	15 min.	1	12655.00	16.47	208427.85	
Transitional Living Rural Differential Tier 3	15 min.	1	12655.00	18.02	228043.10	

GRAND TOTAL: 116516719.37

Total Estimated Unduplicated Participants: 2727

Factor D (Divide total by number of participants): 42727.07

Average Length of Stay on the Waiver: 257