PROVIDER MANUAL

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NORTH Dakota | Health & Human Services

Be Legendary.

DEVELOPMENTAL DISABILITIES SECTION

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SECTION I - INTRODUCTION

This manual functions as a primary reference document for DD licensed providers delivering services covered by North Dakota's Department of Health and Human Services' ("Department") Developmental Disabilities Section ("DD Section"). The DD Section provides support and training to individuals and families in order to maximize community and family inclusion, independence, and self-sufficiency. The DD Section contracts with private, nonprofit, and for-profit organizations to provide an array of residential services, day services, and family support services.

This manual is intended to complement the federal and state rules and regulations, not to supplant it. Any lack of clarity or apparent conflict among the documents is certainly unintended. Should the reader observe such a situation, the federal and state rules and regulations are the final authority.

Traditional IID/DD HCBS Waiver

The Traditional Individuals Intellectual Disabilities/Developmental Disability Home and Community-Based Services Waiver ("Traditional IID/DD HCBS Waiver"), approved by the federal government, allows the state to use Medicaid funding to provide an array of services that allow eligible individuals of all ages the opportunity to receive home-and community-based alternatives to institutional placement. Services provided through the Traditional IID/DD HCBS Waiver are designed to support each individual's full access to the greater community, including opportunities to engage in community life and work in integrated employment settings. Services are arranged through a person-centered planning process that focuses on each individual's personal goals, support needs, and preferences.

You can view the waiver at the Developmental Disabilities website.
https://www.hhs.nd.gov/dd

Medicaid State Plan Services

Individuals who are eligible for Medicaid may also be eligible to receive services under the Medicaid State Plan. The Medicaid State Plan, approved by the federal government, provides traditional medical services such as physician services, lab, hospital, dental, occupational therapy, physical therapy, speech therapy, home health care, etc. Eligibility is determined by the Human Service Zone local office. In addition, Developmental Disabilities Program Managers (DDPMs) can assist eligible individuals to access services under the Medicaid State Plan, such as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) or personal care services.

For details on individual eligibility, covered services, and service limitations, refer to the Human Service Zone local office at https://www.hhs.nd.gov/human-service/zones and document available at https://www.hhs.nd.gov/healthcare-coverage/medicaid.

General Fund Services

General funds, approved by the North Dakota Legislature, are appropriated in limited circumstances only when a service does not qualify for federal Medicaid financial participation or an individual does not qualify for the ICF/IID level of care. For licensing, enrollment, and service authorization procedures, contact the local Regional Human Service Center.

SECTION II - INDIVIDUAL ELIGIBILITY & ENROLLMENT

ACCESS TO SERVICES

The Developmental Disabilities Program Manager (DDPM) has primary responsibility to provide assistance and support to individuals with an intellectual or developmental disability, or a related condition. The DDPM is an employee of the State of North Dakota Department of Health and Human Services. They are in one of the eight regional human service centers across the state. The DDPM is responsible to conduct activities such as intake, determination of eligibility including level of care determinations, assessment of service needs and referral to service providers. The DDPM monitors the plan and the provision of services to ensure that the supports meet the individual's needs and preferences and are delivered according to the individual's approved service plan. DD Program Management is claimed as an administrative activity through Medicaid under the waiver for specific activities. Targeted Case Management may be provided under the Medicaid State Plan for individuals receiving Personal Care under the MSP and no waiver services.

Link to regional human service centers: https://www.hhs.nd.gov/dd-offices

The criteria used to determine eligibility for IID/DD Medicaid services and IID/DD Program Management services are different. An individual may be eligible for IID/DD Program Management per North Dakota Administrative Code (NDAC) 75-04-06 but may not meet the criteria for services covered by Medicaid.

In these situations, the individual would be eligible to receive the service of DD Program Management, but could not access Title XIX Medicaid funding, i.e. Traditional IID/DD HCBS Waiver or Medicaid State Plan (MSP) services.

Link to DDPM eligibility process:
https://www.hhs.nd.gov/sites/www/files/documents/Developmental%20Disabilities/11.1.b.%20%20Process%20to%20Obtain%20DDPM%20and%20DD%20Services%209.28.23.pdf

Birth through Age Two (NDAC 75-04-06-04)

1) Service eligibility for children from birth through age two is based on distinct and separate criteria designed to enable preventive services to be delivered. Young children may have conditions which could result in substantial functional limitations if early and appropriate intervention is not provided. The collective professional judgment of the team must be exercised to determine whether the child is high risk or developmentally delayed, and if the child may need early intervention services. If a child, from birth through age two, is either high risk or developmentally delayed, the child may be included on the caseload of an intellectual disabilities-developmental disabilities case manager and considered for those services designed to meet specific needs. Eligibility for continued service inclusion through intellectual disabilities-developmental disabilities case management must be redetermined by age three using criteria specified in section 75-04-06-02.1.

2) For purposes of this section:

a. "Developmentally delayed" means a child, from birth through age two:

(1) Who is performing twenty-five percent below age norms in two or more of the following areas:

(a) Cognitive development;
(b) Gross motor development;
(c) Fine motor development;
(d) Sensory processing (hearing, vision, haptic);
(e) Communication development (expressive or receptive);
(f) Social or emotional development; or
(g) Adaptive development; or

(2) Who is performing at fifty percent below age norms in one or more of the following areas:

(a) Cognitive development;
(b) Physical development, including vision and hearing;
(c) Communication development (expressive and receptive);
(d) Social or emotional development; or
(e) Adaptive development.

b. "High risk" means a child, from birth through age two:

(1) Who, based on a diagnosed physical or mental condition, has a high probability of becoming developmentally delayed; or

(2) Who, based on informed clinical opinion which is documented by qualitative and quantitative evaluation information, has a high probability of becoming developmentally delayed.

Age Three and Up (NDAC 75-04-06)

An individual is eligible for IID/DD Program Management services if he or she meets one of the three following criteria:

1) The individual has been diagnosed by an appropriately licensed professional with an intellectual disability, which is severe enough to constitute a developmental disability in accordance with the definition of developmental disability in North Dakota Century Code section 25-01.2-01;

2) The individual has been diagnosed by an appropriately licensed professional with a condition of intellectual disability, which is not severe enough to constitute a developmental disability, and the individual must be able to benefit from treatment and services; or

3) The individual has a condition, other than mental illness, severe enough to constitute a developmental disability, which results in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with the condition of intellectual disability, and the individual must be able to benefit from services and intervention techniques which are so closely related to those applied to an individual with the condition of intellectual disability that provision is appropriate.

In order to assess an individual's eligibility, a DDPM will meet with the individual and legal decision maker to collect intake information to determine service needs, which includes completing the Progress

Assessment Review (PAR). The PAR is the tool used to determine if the individual meets ICF/IID Level of Care. The Regional Eligibility Team, comprised of at least three professionals at the Regional Human Service Center, is responsible for determining eligibility under NDAC 75-04-06.

Notification of Individual Eligibility

If an applicant is found to be eligible for IID/DD services, the DDPM contacts the individual to assist in selecting appropriate services and DD providers. Upon selection of services and providers, the DDPM refers the individual to the preferred providers to begin receiving services. Upon receiving a referral, the DD provider communicates with the DDPM on the agency's decision to provide their services.

If an applicant is determined not eligible for IID/DD services, the DDPM provides the applicant with a written notification of denial, which includes the reason for ineligibility and their right to appeal the decision.[1]

All DD providers can confirm a individual's eligibility for services by:

1) *Contacting a DDPM at the appropriate Regional Human Service Center*.

2) *Referencing the individual's service plan*. The provider should check the frequency, amount, and funding source of the services prior to delivery.

3) *Contacting the AVR system (1-877-328-7098) to check the individual's Medicaid eligibility status.* It is recommended that the DD provider check the Medicaid eligibility at least once a month to ensure the individual remains eligible.

Traditional IID/DD HCBS Waiver

The number of individuals served under the Traditional IID/DD HCBS Waiver is limited to the capacity specified in the federally approved Traditional IID/DD HCBS Waiver. An eligible individual must meet all the following criteria:

1) Be a resident of North Dakota and be living in North Dakota;
2) Be eligible for North Dakota Medicaid;
3) Meet the eligibility criteria in NDAC 75-04-06;
4) Meet the ICF/IID level of care; and
5) Be in need of at least one monthly Traditional IID/DD HCBS Waiver service.

Along with eligibility under NDAC 75-04-06, a DDPM will complete the PAR to determine if the individual meets the criteria for ICF/IID level of care to access federal Medicaid funding under the Traditional IID/DD HCBS Waiver. The individual's PAR level ("the HCBS indicator") will determine if the individual is eligible for the ICF/IID level of care to access the Traditional IID/DD HCBS Waiver. If the individual is not already receiving Medicaid, the DDPM will assist the individual in the application process.

[1] Medicaid recipients have certain rights under the law and must be informed of their right to appeal whenever a service is denied, reduced, suspended or terminated or whenever they are denied the choice of Traditional IID/DD HCBS Waiver services or choice of qualified providers.

Eligible individuals will be enrolled in the Traditional IID/DD HCBS Waiver on a first-come, first-served basis until the Traditional IID/DD HCBS Waiver capacity is reached, excluding any reserved slots. When the enrollment capacity has been reached, the DD Section will keep a waiting list based on the date of application.

Medicaid State Plan Services

The Human Service Zone local office determines financial eligibility for Medicaid Health Care Coverage. Depending on an individual's amount of income (or for children, on their parent(s) or legal decision maker's income), individuals may be eligible for full Medicaid benefits or may be responsible for a portion of their medical bills, which is called their recipient liability. General Medicaid income eligibility levels change annually, and can be found on the DHHS website: https://www.hhs.nd.gov/eligibility-and-how-apply.

General Fund Services

In order to access services in this section, an individual must be eligible for DD Program Management per NDAC 75-04-06 and have a need for the service(s).

SECTION III - SERVICES

Traditional IID/DD HCBS Waiver

Below is a list of the provider-managed and self-directed services available under the Traditional IID/DD HCBS Waiver for eligible individuals.

For detailed information on covered services, service limitations, individual eligibility, DD provider qualifications, and recordkeeping requirements for each service, refer to the **"*Service Descriptions*"- Appendix A**.

Provider-Managed Services Delivered by DD Licensed Providers

- Day Habilitation
- Independent Habilitation
- Individual Employment Supports
- Prevocational Services
- Residential Habilitation
- Small Group Employment Supports
- Family Support Services
    - In-Home Supports (IHS)
    - Family Care Option (FCO)
    - Extended Home Health Care (EHHC)
    - Parenting Supports
    - Respite
- Infant Development (ID)
- Community Transition Services

Provider-Managed Services Delivered by Qualified Service Providers (QSPs)

- Adult Foster Care (AFC)
    - Adult Foster Care (AFC) Respite
- Homemaker

Self-Directed Services

- Behavioral Consultation
- Environmental Modifications
- Equipment and Supplies
- In-Home Supports (IHS)
- Respite
- Remote Monitoring

Medicaid State Plan Services

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Personal Care Services

General Fund Services

- Corporate Guardianship

- Section 11 Funds

SECTION IV - TERMINATION OF SERVICES

This section details the procedure for termination of Traditional IID/DD HCBS Waiver, Medicaid State Plan, and General Fund.

Procedures Pertaining to DD Licensed Providers Voluntary Discharge by Individual

Individuals and/or their legal decision makers have the right to choose to participate in services and to select between services and providers. A voluntary discharge is when an individual chooses to exit services and/or chooses another DD licensed provider.

An in-person team meeting will be offered by the Program Coordinator prior to the termination of services. The individual and/or their legal decision maker will be invited to attend although they may choose not to. If a meeting is held, the following agenda items will be covered, and any discussion documented.

In any event, the DD licensed provider will write a "Discharge Summary" addressing each of the following areas:

1) Brief recapitulation of findings, events, and progress during the period of service to the individual;
2) Reasons for the discharge;
3) Potential impact the discharge may have on the individual;
4) Opportunities to prevent discharge, specific recommendations, and arrangements for alternative services; and
5) Termination of services on the Individual Service Plan (ISP) and Overall Service Plan (OSP).

The updated OSP that documents the discharge meeting and/or the Discharge Summary must be submitted to the individual and/or legal decision maker and DDPM within 10 business days following the meeting.

When an individual's services are permanently terminated from a provider, the provider agency must unenroll the individual from the program(s) and must "discharge" the individual from Therap within 30 calendar days of service termination. The discharge must be completed so the provider no longer has access to the individual's Therap file and information after the date of discharge from the provider.

Procedures Pertaining to DD Licensed Providers Involuntary Discharge of Individual

Involuntary discharge occurs when a DD licensed provider has decided to discontinue services and terminate supports even though the individual has not requested the termination of services. Any opportunities to prevent an involuntary discharge should be explored prior to the discharge by the provider. DD licensed providers must have written policies and procedures that define the conditions of termination and transfer of individual services. Individuals and/or legal decision makers should receive

a copy of the provider's policy at the time of admission to the provider agency and again when discharge is being considered.

In the case of an involuntary discharge, the DD licensed provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting, and complete a written discharge summary. The written discharge notice must include the reason for the discharge, why the provider cannot continue to serve the individual, the provider's grievance policy, and the individual's right to appeal the provider's decision within the provider agency. A copy of this written discharge notice must be forwarded to the Developmental Disabilities Regional Program Administrator (DDRPA).

Any opportunities to prevent discharge and preserve the person's placement should be explored prior to the discharge by the provider. This includes contact with the regional Behavior Analyst and Clinical Assistance, Respite, and Evaluation Services (CAREs) team to request formal consultation and technical assistance. CAREs consultation is available for challenging behaviors and/or medical conditions. The request for additional assistance should be made as soon as the provider and team members are aware that the placement may be compromised. Seeking services from the CAREs team when concerns have been ongoing, and discharge is imminent is not acceptable.

The DD licensed provider must schedule an in-person team meeting and the meeting must be held before the provider issues the written 30-day discharge notice. It is the responsibility of the Program Coordinator to schedule the meeting. Participants must include the person and/or legal decision maker, DD Program Manager, and other team members.

The following agenda items should be covered during the discharge meeting and write a "Discharge Summary" addressing each of the following areas:

a. Brief recapitulation of findings, events, and progress during the period of service to the individual;
b. Reasons for the discharge;
c. Potential impact the discharge may have on the individual; and
d. Opportunities to prevent discharge, specific recommendations, and arrangements for alternative services.

The provider is responsible for documenting all discussions and decisions made during the discharge planning meeting in the individual's OSP. Following the meeting, the DD licensed provider must also prepare a "Discharge Summary". The discharge summary and the updated OSP must be submitted to the individual and/or the legal decision maker and the DDPM within ten (10) business days following the discharge meeting.

When an individual's services are permanently terminated from a provider, including death, the provider agency must unenroll the individual from the program(s) and must "discharge" the individual from Therap within 30 calendar days of service termination. The discharge must be completed so the provider no longer has access to the individual's Therap file and information after the date of discharge from the provider. If the individual dies while receiving services in an ICF, the provider may want to print off documentation before "discharge" of the individual in Therap, for Title XIX reviews.

If there is an open investigation being conducted by law enforcement, P&A or ICPS/CPS, or other entity, the provider must wait until the results and findings of these investigations have been completed before completing the discharge of the person's case in Therap.

Termination Procedures Pertaining to DD Licensed Provider

The Department may deny a license to an applicant or revoke an existing license upon a finding of noncompliance with the rules of the Department.

1. If the Department denies a license, the applicant may not reapply for a license for a period of six months from the date of denial. After the six-month period has elapsed, the applicant may submit a new application to the Department.

2. If the Department revokes a license, the licensee may not reapply for a license for a period of one year from the date of the revocation. After the one-year period has elapsed, the licensee may submit a new application to the Department.

3. A license denial or revocation may affect all or some of the services and facilities operated by a licensee.

Termination Procedures Pertaining to Qualified Service Providers (QSPs)

QSPs may be terminated by Medical Services/HCBS with input from Legal & the Fraud Unit. Basis for termination may include nonperformance of standard care, insufficient competencies, fraudulent billing practices, and abuse, neglect, or exploitation of a recipient. Reference NDAC 75-03-23-08 for additional information. QSPs may appeal such termination in accordance with NDAC 75-01-03.

SECTION V - DD PROVIDER LICENSING & ENROLLMENT

According to NDAC 75-04-01-17 services provided to individuals eligible per NDAC 75-04-06 for Developmental Disabilities Program Management must be identified and licensed.

The following services are subject to licensure through the DD Section:

- Residential Habilitation
- Day Habilitation
- Independent Habilitation
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Employment Supports
  - Small Group Employment Support
  - Individual Employment Support
- Prevocational Services
- Family Support Services
  - Parenting Supports
  - In-Home Supports (IHS)
  - Extended Home Health Care (EHHC)
  - Family Care Option (FCO)
  - Respite
- Infant Development (ID)

Agency Licensing Process

New Providers

Providers that are not currently licensed by the DD Section to provide services to eligible individuals will be required to complete the following items:

1) Letter of Intent (SFN 1793), Agency Information page from the New Provider Packet, Business Plan, & 3 letters of reference by individuals knowledgeable of the applicant and of the delivery services to persons.
   - All documents must be submitted to the DD Licensing Administrator
2) New DD Provider Orientation
   - Upon receipt of the required documents, the Licensing Administrator will inform the applicant of the next scheduled "New DD Provider Orientation" session provided by the DD Section. New DD Provider Orientation is held quarterly throughout the year. The applicant is required to attend the orientation in its entirety and is the first step in the licensing process.

***These two items need to be completed before proceeding with the steps identified below.**

Once the required documentation is submitted and applicant attends the DD New Provider Orientation, the applicant is required to participate in several pre-application trainings and meetings with staff of the Developmental Disabilities Section and their contractors. The intent of these trainings and meetings is

to provide the applicant with an overview of the ND DD service delivery system and acquaint them with the expectations and requirements that need to be fulfilled by the applicant to obtain a license to provide services. It is also important for the applicant to know if the service the applicant is proposing to provide can be authorized and paid for by the department.

1) Accreditation through a Department approved accreditation agency.
   - Per NDAC 75-04-01, providers are required to be accredited and must obtain initial accreditation within a year of receiving a provisional license.
   - The applicant must engage with one of the approved accreditors before being approved for a license. Verification of accreditation engagement must be submitted to the Licensing Administrator.
   - The applicant is responsible for all costs associated with accreditation and all ongoing accreditation costs.
   - Providers are required to maintain accreditation.

   **Refer to the Accreditation section of this manual for additional information and for the list of the Department approved accreditation entities.*

2) Abuse, Neglect, and Exploitation Training with North Dakota Protection & Advocacy. The applicant will be notified of the training dates.

3) North Dakota Center for Persons with Disabilities (NDCPD) Introduction Training
   This preliminary training to North Dakota Center for Person with Disabilities (NDCPD) is to create your provider training material and be educated on the training modules. The applicant will be provided with the details for this training.

4) North Dakota Center for Persons with Disabilities (NDCPD) Training
   - In-depth training to North Dakota Center for Person with Disabilities (NDCPD) to create your provider training materials and be educated on the training modules. The applicant will be provided with contact information for the director of staff training at the North Dakota Center for People with Disabilities (NDCPD) for instructions on the Guidelines and Syllabus and additional procedures required for staff training.

5) Complete the Overall Service Plan Provider Exercise
   - The applicant will review the requirements for person-centered service plans (OSP, IFSP) policies and procedures and qualifications, roles, and responsibilities of the Qualified Developmental Disability Professional (QDDP). The applicant will then complete this exercise to help build familiarity with service plan elements, including goat setting, health and safety needs, and restrictions.
     - Review the OSP instructions located at ND Developmental Disabilities Section-Overall Service Plan Instructions
     - Attend DD Section training on the OSP instructions and QDDP responsibilities. You will receive notification of the scheduled training. This training is essential for new providers to gain insight into the requirements and development of person-centered service plans.
       - *This training does not need to be completed prior to obtaining initial licensure. The training needs to be completed as soon as possible or, at*

the latest, within a year of the effective date of the initial license.

- Complete the required QDDP modules through NDCPD. These modules are required for staff who will be developing person-centered service plans for the agency.
  - *These modules are not required to complete prior to obtaining initial licensure, but needs to be completed according to the policy PI-18-05 Staff Training-DD Licensed Providers located at* DD Training Policy 4.1.23 FINAL.pdf.

5) Policies and Procedures
   - The applicant will develop agency policy and procedures according to applicants guarantees and assurances found in the New Provider Packet and NDAC 75-04-01-20.1.a-y at nd1.ac_web
   - The DD Section will review the applicant's policies and procedures to ensure DD's policies and requirements are reflected, and they are not in conflict with any state or federal policies and procedures.
   - The DD Section may request changes or make suggestions before accepting the policies and procedures.

6) Introduction to Regional DD Program Management
   - The applicant will schedule a meeting with the Regional DD Program Administrator (s) at the human service center(s) in which the applicant plans to provide services to: discuss the roles and responsibilities of regional DD program management; understand the local referral process, local monitoring requirements; DD program management resources; service authorization and approval; as well as the specific needs of the region(s) and provide written verification that the meeting was held.

New providers will also be provided with a "New DD Provider Checklist" that will lay out all the required steps for licensure, in addition to the items listed above. This checklist will provide DD Section staff contact information and valuable information toward becoming a provider.

Upon completion of the above items, the applicant will submit the licensure packet to the Licensing Administrator at the DD Section if the applicant is still interested in providing DD Licensed services in ND. The packet consists of the North Dakota DD Provider Application (SFN 1794). All the items contained on the form, required inspections, and New DD Provider Checklist, must be completed and sent to the DD Section before being licensed and before any services can be provided. An application is not complete until all required information and verifications are submitted.

***Refer to Section XVI-Licensing Handbook & Forms-Appendix D of this manual for the complete listing of the required licensing forms. All forms pertaining to initial licensing or renewals can be accessed at: https://www.nd.gov/eforms**

The application packet will be reviewed by the Licensing Administrator in the DD Section, and other DD staff as deemed appropriate, to determine if all necessary information is enclosed and the requirements for a license are met and in compliance with the licensing rules.

Arrangements for a site survey may be made if deemed necessary. This potential site survey will be scheduled for the mutual convenience of the provider and Licensing Review unless the effectiveness of the inspection would be substantially diminished by prearrangement.

a. If deficiencies are found, concentrated efforts of the service provider for correction and compliance will be necessary.

For ICF/IID facilities, a certification survey will be conducted by the Health Facilities Unit and Life Safety.

Once review of the application and inspections (as appropriate) has begun, the applicant will be contacted regarding any follow-up questions or if any additional materials are required. A plan of correction may be issued to the applicant and any noted deficiencies must be remediated prior to issuing a licensure.

The length of time to complete the application review process is dependent on the completeness of the initial application/supplemental materials and the response time of the applicant to any request for updated or additional information. Per Administrative code, the DD Section has 60 days to review the completed application and its contents but may take longer depending upon information provided and any follow-up needed by either party.

If an applicant fails to submit all required information, the application is incomplete and will not be approved. If the applicant fails to submit all the required information and verifications within 30-days of the notification of an incomplete application, the application may be withdrawn.

Upon completion of the review of the licensure packet and site visit, if appropriate, a determination to issue or deny a provisional license request will be made. If the requirements have been met, a provisional license certificate will be issued to the successful applicant. Accreditation must be obtained within one year of the issuance of the provisional license. The provider is responsible for the activities required for the accreditation timelines.

If the applicant will provide ICF/IID services, the approved Medicaid Agency Certification must be completed before the DD license is approved.

Existing DD Providers/Annual Renewal/New Services

Providers that are currently licensed by the DD Section to provide services to eligible individuals will be required to complete the following items:

1) 120 days prior to licensure expiration, a notice will be sent to the service provider containing a reminder of upcoming licensure expiration date(s) and the necessary requirements for re-licensure

2) The provider will submit the licensure packet SFN 1794 (i.e. application, required inspections, etc.) to the DD Section sixty (60) days prior to starting any approved services or expiration of an existing license. If the provider is not able to provide the licensure packet within this timeframe, a request to waive the sixty (60) days submission timeline must be submitted to the DD Licensing Administrator. If a renewal licensure packet is not received and a request to waive the sixty (60) days submission timeline has not been received, the DD Section will contact the provider to confirm the provider's intent to continue services. A provider's failure to submit the

renewal licensure packet timely may result in the termination of services, which would result in the transition of individuals.

3) Once the application is returned to the DD Section, it will be reviewed, and a determination of compliance will be made. Arrangements for a site survey may be made if deemed necessary. This potential site survey will be scheduled for the mutual convenience of the provider and Licensing Review unless the effectiveness of the inspection would be substantially diminished by prearrangement.
    a. If deficiencies are found, concentrated efforts of the service provider for correction and compliance will be necessary. This may result in a plan of correction for the provider.

4) Upon completion of the review of the licensure packet, a determination to issue or deny a license request is made. The following types of licenses may be issued pursuant to the license application review:

    - Unrestricted - issued to an applicant, which complies with the rules and regulations and has received, and maintains, accreditation from a department-approved national organization.

    - Restricted - issued to a licensee with an acceptable plan of correction notwithstanding a finding of noncompliance with the rules of the department and North Dakota Century Code section 25-16-03

5) The above licenses are issued for periods of up to one (1) year, are non-transferable, and are valid only for those services shown on the license certificate.

6) Every five years, each provider will need to re-verify their information in HE MMIS. The DD Section will notify the DD provider of this requirement and the steps necessary.

***Refer to Section XVI-Licensing Handbook & Forms-Appendix D of this manual for the complete listing of the required forms. All forms pertaining to initial licensing or renewals can be accessed at: https://www.nd.gov/eforms**

Change in Licensure

Providers must request a change in licensure when there is a change of control or ownership of the licensed provider; to provide a new service they are not currently licensed for; to add an additional region or county they are not currently licensed for; to terminate a service they are currently licensed to provide; or to increase the licensed capacity. Each license certificate shows maximum capacity, so it is unnecessary to request a change in licensure should individual/resident census fall below that capacity shown.

Circumstances warranting a change in licensure will be either of a planned or an emergency nature. Simple changes (such as a request for an increase in licensed capacity) will result in the issuance of a revised certificate. More complex changes may result in the issuance of a restricted license. The following procedures apply to planned, emergency, or termination situations:

1) Planned

- Licensee submits license application for service(s) affected with details of change, at least thirty (30) days prior to the change(s) taking place.

- Upon review and approval by Licensing Administrator and the Regional Developmental Disabilities Program Administrator, a license certificate will be issued prior to the change.

2) Emergency

   Licensee contacts licensing administrator to request verbal approval. Licensing administrator will document the verbal application and if appropriate grant approval. The licensee then forwards the hard copy application.

   - Upon receipt and review of license application and approval of the Regional Developmental Disabilities Program Administrator, licensing administrator will issue a license certificate to accommodate the emergency.

3) Termination of Services
   - Licensee submits license termination request for service(s) affected with details of discontinuance, at least thirty-days (30) prior to the termination of service(s).

   - Upon receipt and review of license termination request, and approval of the Regional Developmental Disabilities Program Administrator, formal acknowledgment of license discontinuance will be issued to the licensee.

Accreditation

All DD licensed providers are required to obtain and maintain accreditation as identified in NDAC 75-04-01-15. All costs associated with accreditation are the responsibility of the provider. If a provider does not maintain accreditation, a restricted license will be issued in accordance with NDAC 75-04-01-03.1 until the provider is in compliance with accreditation.

DD licensed providers shall submit copies to the DD Section of reports generated by the accreditation process.

The accreditation process is focused on people living meaningful and fulfilling lives, and the efforts providers make during the process means better person-centered services for people supported. When recommendations are made, agencies are expected to comply with those recommendations or demonstrate that progress is being made towards compliance with those recommendations.

There are multiple department-approved national accreditation organizations from which providers may choose to obtain accreditation. Providers have the responsibility to determine which accreditation organization below aligns with their needs and objectives.

- CARF

- The Council on Quality and Leadership

- The Joint Commission
- National Association for Dual Diagnosis (NADD)
- Social Current / Council on Accreditation (COA)

For detailed information on accreditation, refer to the department's website at: https://www.hhs.nd.gov/dd/information-dd-licensed-providers.

DD Licensed Provider Enrollment

The provider will need to complete the following:

1) Medicaid Program Provider Agreement (SFN 615), Developmental Disabilities Provider Addendum (SFN 569), Ownership Controlling Interest and Conviction Information (SFN 1168), W-9, and DD Purchase of Service Agreement; and
2) Health Enterprise MMIS Provider Enrollment Application (https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment).

For detailed information on this section, refer Appendix D in this manual.

Qualified Service Provider (QSP) Enrollment for Traditional IID/DD HCBS Waiver Services (Homemaker & Adult Foster Care)

The following is required for services provided by a QSP:

1) Compliance with NDAC 75-03-23-07; and
2) Must enroll as Qualified Service Provider (QSP) with the State Medical Services Division ("Medical Service/HCBS") for Homemaker and the State Aging Services Unit for Adult Foster Care.

Prior to service delivery, QSPs must ensure that all direct service staff meet the certification and competency requirements described in NDAC 75-03-23-07.

For detailed information regarding required forms and staff qualifications, and renewal of QSP status, refer to the QSP information, available on the DHHS website: http://www.nd.gov/dhs/services/adultsaging/providers.html.

SECTION VI - PROVIDER REQUIREMENTS

As part of its quality improvement strategy, the DD Section is responsible for monitoring service implementation, individual safety and satisfaction, and integrity of submitted claims. All providers are required to adhere to the rules, standards, and documentation requirements described below. This list is not an all-inclusive list.

Rule	Rule Title and Reference
CFR Titles 34, 42, 45	Code of Federal Regulations most referenced relating to Developmental Disabilities and Home and Community-Based Services. Found at: https://www.ecfr.gov
Individuals with Disabilities Education Act (IDEA)	Found at: http://idea.ed.gov
The Rehabilitation Act of 1973	Found at: http://www.ed.gov/policy/speced/reg/narrative.html
NDCC 25-01.2	Developmental Disability Found at: http://www.legis.nd.gov/general-information/north-dakota-century-code
NDCC 25-16	Residential Care and Services for the Developmentally Disabled Found at: http://www.legis.nd.gov/cencode/t25c16.pdf?20141114093503
NDCC 25-16.1	Receivers for Developmentally Disabled Facilities Found at: http://www.legis.nd.gov/cencode/t25c16-1.pdf?20141114093656
NDCC 25-16.2	Work Activity Center Contract Awards Found at: http://www.legis.nd.gov/cencode/t25c16-2.pdf?20141114093719
NDCC 25-18	Fee for Service Rate Setting for Developmentally Disabled Facilities Found at: http://www.legis.nd.gov/cencode/t25c18.pdf?20141114093754
NDCC 50-06	Department of Human Services Found at: http://www.legis.nd.gov/cencode/t50c06.pdf
NDCC 50-06.2	Comprehensive Human Services Programs Found at: http://www.legis.nd.gov/cencode/t50c06-2.pdf
NDCC 50-11	Foster Care Homes for Children and Adults Found at: http://www.legis.nd.gov/cencode/t50c11.pdf
NDCC 50-24.1	Medical Assistance for Needy Persons Found at: http://www.legis.nd.gov/cencode/t50c24-1.pdf
NDAC 75-03-21	Licensing of Foster Homes for Adults Found at: http://www.legis.nd.gov/information/acdata/pdf/75-03-21.pdf

Rule	Rule Title and Reference
NDAC 75-03-23-07	Policy, rules and regulations for Qualified Service Providers (QSPs) Found at: http://www.legis.nd.gov/information/acdata/pdf/75-03-23.pdf
NDAC 75-04-01	Licensing of Programs and Services for Individuals With Developmental Disabilities Found at: http://www.legis.nd.gov/information/acdata/html/75-04.html
NDAC 75-04-05	Reimbursement for Providers of Services to Individuals With Developmental Disabilities Found at: http://www.legis.nd.gov/information/acdata/html/75-04.html
NDAC 74-04-06	Eligibility for Intellectual Disabilities-Developmental Disabilities Program Management Services Found at: http://www.legis.nd.gov/information/acdata/html/75-04.html
DD Section Policy	For detailed information on DD Section Policy, refer to the DD Bookshelf: https://www.nd.gov/dhs/policymanuals/816/816.htm, select "PI's/Outstanding PI's" on the left hand side.

Informing Individuals of Their Rights

Every DD licensed provider shall post conspicuously in public areas a summary of the rights defined in NDCC 25-01.2. Individual rights, such as the DD Bill of Rights, should be reviewed initially and an on an annual basis by the team during the person-centered planning process. In addition, upon commencement of services or as soon after commencement as the individual's condition permits, every individual eighteen (18) years of age or older, the parents or the custodian of all individuals under eighteen (18) years of age, and the guardian must be given written notice of the rights guaranteed by the aforementioned chapter.

Confidentiality Requirements

NDAC 75-04-01 requires DD licensed providers to maintain a confidentiality policy. Such policies must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DD licensed providers must update the DD Section of any change in the policy of confidentiality.

Certification

1) ICF/IID facilities are institutions that participate in Medicaid and must comply with specific Medicaid standards; meeting applicable requirements and evaluation of quality of care. The survey for the determination of standards, collectively known as the certification process, is done on behalf of CMS by individual State Survey Agencies. In North Dakota, it is completed by the Department of Health and Human Services, Health Facilities Unit.

   Certification is completed initially and annually for each ICF/IID facility (home) based on the agency's ability to comply with Condition of Participation for ICF/IID's.

For more detailed information, refer to the DHHS website:
https://www.hhs.nd.gov/sites/www/files/documents/Developmental%20Disabilities/16.5.b.%20Title%20XIX%20Procedures%20for%20Providers.pdf

Requirements for DD Licensed Providers

Licensees are required to record and report the following:

1) Documentation to demonstrate the right to receive payment for all services and supports and comply with all federal and state laws necessary to disclose the nature and extent of services provided and all information to support claims submitted by the provider.
2) Submit a statement of policies and procedures, and evidence of implementation to prove compliance with departmental rules and NDCC 25-01.2
3) Licensees shall maintain program records, fiscal records and supporting documentation identifying items, including:
    a. Authorization from the DD Section for each individual whom service is being provided;
    b. Attendance sheets and other records documenting the days and times that the individuals received the services/tasks from the licensee; and
    c. Records of all bills submitted to the Department for payment.
4) Maintain supporting documentation and fiscal records ensuring that claims are coded and paid for in accordance with the Department's reimbursement methodology as defined in NDAC 75-04-05-08.
5) Retain a copy of the required records for six (6) years from the date of the bill unless an audit in process requires a longer retention.
6) Document compliance with the guarantees and assurances defined in NDAC 75-04-01.

Provider Integrity Audit

Federal regulations (42 CFR 456) stipulate that each State Medicaid Agency utilize surveillance and review process to protect the integrity of the program. The purpose of this requirement is to avoid unnecessary costs to the program due to fraud or abuse and assure that eligible recipients receive quality and cost-effective medical care.

The Medicaid State Plan and the Traditional IID/DD Home and Community-Based Services (HCBS) Waiver are the North Dakota Medicaid agency's agreements with the federal government that details Medicaid coverage and payment for services and program operations.

Annually, or as needed, the DD Section will determine audit topics relative to the services provided by the DD Section.

For detailed information on this section, refer to the DHHS website:
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/dd-provider-integrity-manual.pdf

Building Design and Safety Requirements

All DD licensed providers must ensure that the building meets the safety requirements and regulations, including local zoning laws, occupancy rates, life safety codes, sanitation, emergency plans, CMS Final Rule on HCBS setting and access to essential utilities as required by NDAC 75-04-01.

Group homes must satisfy additional building design and safety codes specified in NDAC 75-04-01-27 through 75-04-01-31. The "*Physical Standards Checklist*" for group homes is available at http://www.nd.gov/eforms/Doc/sfn01555.pdf. Group homes must allow for all bedrooms to have lockable doors, except where individuals may not lock their own rooms due to a specific assessed need or safety concern as consistent with their person-centered service plan. Please reference 42 CFR 441.301(c) (4)-(5) for additional details.

In accordance with NDAC 75-04-01-24, DD licensed providers must allow authorized representatives of the Department to inspect the service facilities and records. To prove compliance with safety requirements, the DD licensed provider must have a license or registration certificate issued pursuant to NDCC 50-11 or possess written statements by accredited professionals as described in NDAC 75-04-01-22.

Individual Documentation and Reporting for DD Licensed Providers

The DD Section requires providers to comply with the following data collection, documentation, and reporting requirements. Please reference NDAC 75-04-01, 75-04-05, and "*North Dakota Developmental Disabilities Service Description Manual"* for details. Please reference Medicaid Program Provider Agreement (SFN 615).

Therap Software

Therap, the Department's official source of individual registration and record, is a HIPAA compliant, web-based case management system.

Required Therap modules for providers include:

- Overall Service Plan (OSP)
- Individualized Family Service Plan (IFSP)
- General Event Reporting (GER)
- Individual Referral
- Individual Data Form (IDF)
- Risk Management Assessment and Plan (RMAP)

Required Therap modules for Department staff include:

- Individual Eligibility
- Progress Assessment Review (PAR)
- Overall Service Plan (OSP)
- Individual Support Plan (ISP)
- Case Action
- Progress Notes
- Quality Enhancement Review (QER)
- Individual Referral
- Individual Authorizations
- Risk Management Assessment and Plan (RMAP)

Reference the Therap Website for how to tutorials https://help.therapservices.net/app/north-dakota.

At the point of licensure, the Department will initiate the registration for Therap. The Therap Help Desk will contact the provider with security login information.

Abuse, Neglect, and Exploitation Reporting

The Department is committed to ensuring that all individuals receiving DD services are treated with dignity and respect, receive services and supports designed to meet their individual needs, and are able to live safe and secure lives in their respective communities.

In accordance with DD Section policy and NDAC, DD licensed providers are required to report Serious Events and Reportable Incidents.

If a DD licensed provider fails to report any suspected incidents of abuse, neglect, or exploitation; the DD Section staff, Regional DD Program Management and/or P&A may launch a formal investigation. Applicable corrective action may include but is not limited to notification to the Health Facilities Unit for ICF/IID, notification of the accreditor, licensure sanctions, and/or revocation of the provider's license.

For detailed information on this section, refer to the DD Bookshelf: http://www.nd.gov/dhs/policymanuals/816/816.htm, select "PI's/Outstanding PI's" on the left-hand side.

Day-to-Day Monitoring

All DD licensed providers are responsible for day-to-day monitoring and service plan implementation, and hence, must maintain the following individual documentation to facilitate census data auditing and periodic quality reviews.

The QDDP module, available through North Dakota Center for Persons with Disabilities (NDCPD), may include additional documentation requirements.

Maintain daily census records for all individuals, regardless of payer source. These records must include:

1. Identification of the individual;
2. Entries for all days that services are offered including the duration of service;
3. Identification of type of day, i.e., hospital, in-house.

Providers must record progress notes, including data, where applicable, to monitor progress towards goals and objectives. All notes must include the signature/initials of the staff member providing the service to verify that services were delivered for the identified individual.

Provider Survey

Survey Domains

The purpose of the survey is to determine compliance with federal and state standards; to assure health and welfare; and review quality of services. The survey reviews provider's Home and Community-Based Services Waiver in the following areas:

- Service Planning, Delivery, and Implementation;

- Rights;
- Provider Capabilities and Qualifications;
- Health and Safety;
- Financial Management.

Off-Site Desk Review

The off-site activities provide the surveyor with information that can be reviewed prior to the on-site in combination with other on-site activities, will provide background information, and is a time to collect and analyze data. This allows greater flexibility during the on-site review and facilitates a more efficient review. A sample of individuals is determined, and the provider will be notified 1 week prior to the on-site review. Off-site activities include but are not limited to:

- Provider will receive a letter requesting documents and information;
- Information and feedback are gathered from other entities (may include HSC, Licensing, Accreditation Entities, Title XIX);
- Desk review of documents via Therap or by the provider;
- Guardian phone interviews.

On-Site Review

Surveys may begin with a brief entrance discussion for the purpose of introductions, organizational information, survey logistics, and finalization of schedules. Providers will be notified of the staff sample upon the arrival of the surveyor. On-site activities include but are not limited to:

- Observations in service settings;
- Review of personnel records and other supporting documentation as needed;
- Discussions with individuals and staff;
- Exit discussion at the conclusion of the survey to discuss preliminary findings.

Determination and Follow-Up Activities

After the completion of the on-site visit, a letter of findings and a written final report will be compiled and includes all areas surveyed. The report will address the provider's strengths, deficiencies cited, and summary of findings during the review.

- Provider will receive the final report within 15 business days of the on-site visit. Within 20 business days of the receipt of the final report, the provider must provide a plan of correction (POC) in response to any deficiency citations.
- The DD Section will notify the provider of the status of their submitted POC within 15 business days. All deficiencies must be corrected within 45 calendar days from the POC approval date. The DD Section will verify correction of all deficiencies.

For detailed information on this section, refer to the DHHS website:
https://www.hhs.nd.gov/sites/www/files/documents/Developmental%20Disabilities/hcbs-provider-survey-handbook.pdf

Electronic Visit Verification (EVV)

Section 12006(a) of the 21st Century Cures Act (link is external) mandates that states implement EVV for all Medicaid personal care services and home health services that require an in-home visit by a provider. This applies to personal care services provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115 and home health services provided under Section 1905(a)(7) of the Social Security Act or a waiver. This is mandatory for Medicaid programs in all states.

The North Dakota Department of Health and Human Services has adopted an open EVV model. Providers may choose to use their own EVV system and will be required to submit data to a data aggregator. Providers will be responsible for working with the aggregator vendor to ensure it meets all requirements and for any interface costs (if any) charged by their vendors if they choose to use their own system.

The Department of Health and Human Services has contracted with Therap LLC as its EVV vendor and Sandata Technologies as the aggregator vendor.

Developmental Disability Services required for EVV

- Homemaker
- Independent Habilitation
- Extended Home Health Care
- In-home Support (provider managed and self-directed)
- Personal Care
- Respite (provider managed and self-directed)
- Adult Foster Care- Respite

Link to the EVV policy- electronic-visit-verification.pdf.
It can be found on the DHHS ND Medicaid Provider information on the Provider Guidelines, Manuals and Policies page. Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota

For more information and updates to EVV visit https://www.hhs.nd.gov/adults-and-aging/electronic-visit-verification-evv-system.

Virtual Supports

The purpose of virtual supports is to maintain or improve an individual's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community.

1. Virtual supports are not a distinct, separate service under the North Dakota 1915c Traditional IID/DD Home and Community Based Services Waiver (DD Waiver), but a method by which certain services may be delivered to an individual.
2. The purpose of virtual supports is to maintain or improve an individual's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community.
3. Virtual supports are geared towards intentional learning (e.g., career planning, taking a cooking class, skill building) and can also be used towards helping a person do something more independently like remote job coaching.

Services Allowed for Virtual Supports

- Behavioral Consultation
- Independent Habilitation
- Individual Employment Services
- Parenting Supports
- Infant Development- Home Visits
- Infant Development- Early Childhood Special Education Consultation

- Infant Development- Nursing Consultation
- Infant Development- Occupational Therapy Consultation
- Infant Development- Physical Therapy Consultation
- Infant Development- Speech Consultation
- Infant Development- Social Work Consultation

For additional requirements, utilization, limits, and provider expectations, refer to the DHHS bookshelf for the Virtual Supports Policy PI-23-13.

Home and Community Based Services in Acute Care Hospital Setting

In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.

The delivery of HCBS in acute care hospital setting is only applicable for individuals receiving Traditional IID/DD HCBS waiver services who are seeking or receiving treatment in an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical conditions, or injuries.

An individual can receive HCBS services in an acute care hospital setting if they are currently authorized for only the following Traditional IID/DD HCBS waiver services:

- Residential Habilitation
- Independent Habilitation
- In-Home Supports, and
- Respite.

Individuals may receive HCBS from their direct support professional while receiving medical care and treatment in an acute care hospital setting so long as the following conditions exist:

1. the need for direct supports in an acute care hospital setting is accurately documented in their Person-Centered Service Plan (PCSP);
2. the direct supports provided meets the need(s) of the individual that are not met through the provision of hospital services;
3. the direct supports do not substitute for services that the hospital is obligated to provide under Federal or State law, or under another applicable requirement; and
4. the direct supports are being provided to ensure a smooth transition between the acute care settings and home and community-based setting and preserve the individual's functional abilities.

This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law. The DD Licensed provider will coordinate with the hospital staff to determine what direct supports are necessary to meet the individual's needs.

If the individual is admitted to an acute care hospital setting, current DD services can continue to be authorized as the admission does not result in a screening to another level of care. The HCBS waiver level of care screening does not get terminated.

All Traditional IID/DD HCBS waiver rules and service limitations still apply.

Day to Day Documentation

All DD licensed providers are responsible for day-to-day monitoring and service plan implementation, and must maintain the following documentation to facilitate census data auditing and periodic quality review if supports are provided in an acute hospital setting the documentation must include the location of the supports in addition to the following:

- Date of service
- Name of DD Licensed provider
- Name of the Service being provided with in/out times for each service
- Individual's name
- Staff who provided service (if using staff initials a legend of staff names must be provided)
- Summary of tasks and activities performed during that time (daily rate providers can meet the requirement by one itemized list of routine tasks and a single entry every day)
- The record should be written in clear language and without alterations

Service Plan Process and Documentation

During the annual service plan meeting or as needed the team will discuss and document the individual needs supports in a hospital setting to ensure a smooth transition between the acute care settings and home and community-based setting and preserve the individual's functional abilities.

- Overall Service Plan will be documented in the Emergency Backup plan section.
- IFSP will be documented in the Summary of Family Concerns, Priorities and Resources section.

Billing

Residential Habilitation-

- If direct supports for an individual are provided while in the hospital, a claim for Residential Habilitation can be submitted.
    - The attendance option of Present-Hospital should be used only when the provider is staffing the individual to provide support while hospitalized and will allow a regular Residential Habilitation unit to be billed.
- If direct supports are NOT provided to the individual while in the hospital, a claim for Residential Habilitation Retainer can be submitted. (Limits still apply for only 30 per calendar year)
    - If no staff is provided, the Absent option should continue to be used, and a Residential Habilitation Retainer unit may be billed as long as the individual has days remaining for the year.

Independent Habilitation, In-Home Supports, and Respite-

- If direct supports for an individual are provided while in the hospital, a claim can be submitted.
- If direct supports are NOT provided to the individual while in the hospital, a claim cannot be submitted.

Census documentation will need to differentiate between hospital stay with no supports and hospital stay with supports.

SECTION VII - CENTER FOR MEDICARE AND MEDICAID (CMS) FINAL HOME AND COMMUNITY-BASED SERVICES (HCBS) RULES

The Centers for Medicare and Medicaid Services (CMS) issued regulations in March 2014 for Home and Community Based waiver services. CMS is part of the federal government that oversees the federal funding used to pay for waiver services. States and providers are required to follow federal regulations in order to receive funding.

The regulations impact where people work, live, and attend day services. The regulations ensure people have **full access** to the benefits of community living based on characteristics and individual experiences; people have the opportunity to receive service in the **most integrated** settings; people have maximum **choice and control** over their lives making big and small life decisions; and **rights are respected** and should be same as any citizen.

Home and community-based services **cannot** occur in the following settings:

- A nursing facility;
- An institution for mental diseases;
- An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- A hospital; or
- Any other locations that have qualities of an institutional setting.

Setting Requirements

The regulations require that all home and community-based settings meet certain qualifications, including:

1. The setting is integrated in the greater community AND supports full access to the greater community.
2. The setting is selected from options that include people without disabilities.
3. Setting must ensure people's rights are respected and promoted.
4. The setting encourages individual initiative, autonomy, and independence in making life choices.
5. The setting provides choice about services/supports and who provides them.
6. Provider owned or controlled residential settings must have a lease and lockable bedroom doors.
7. If there are any modifications to these regulations the provider must follow additional rules:
    a. Base the restriction on a specific individual need.
    b. Show that positive interventions have been tried but haven't worked.
    c. Keep measuring with data collection to determine if restriction should continue.
    d. Show that any modification is TEMPORARY and includes a fading plan.
    e. Informed consent from person and legal decision maker.
    f. Show the intervention will cause no harm.

Person-Centered Service Planning Requirements

The regulations ensure person-centered planning is:

- Developed through a person-centered process that is directed by the individual along with others chosen by the individual to contribute to the process;
- Assisting the individual in achieving their personal outcomes in the most integrated setting;
- Delivering services in a manner that reflects personal preferences and choices; and
- Assuring health and welfare.

Refer to the Overall Service Plan (OSP) instructions for directions on the planning process and documentation needed within the plan.
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/overall-service-plan-instructions-update.pdf

Assuring Initial Compliance

New Home and Community-Based Settings

The provider is responsible to notify the Regional DDPA of any new provider-owned or controlled residential setting, Day Habilitation or Prevocational setting **prior to the setting being initiated, built or purchased.** The DD Section needs to be involved throughout the planning stages of the setting to ensure the setting will comply with the HCBS Regulations, such as physical location, design of the setting, and delivery of services. A complete review needs to be conducted before the setting can be licensed, if applicable.

It is the responsibility of the provider to schedule an onsite review with the Regional DDPA for the prospective location before services are provided in the setting. This review will be conducted by the DDPA in conjunction with the provider. The Regional DDPA will submit the completed review to the Waiver Administrator. The Waiver Administrator will review the submission with the DD Section.

DD Section will respond to initial settings review 10-15 business days from the day it was submitted. The provider should expect to allow time for questions and any changes for the setting that may need to take place to be compliant, while allowing up to 30 business days for the final report to be completed.

If there are any further questions or concerns, the Waiver Administrator will be in contact with the DDPA and/or Provider. The final copy of the review will be provided to the DDPA and Provider after review by the DD Section. All final questions and concerns will need to be followed up and resolved **before** final approval of the setting.

If no response is received from the provider to questions and any changes for the setting that may need to take place to be compliant after 15 business day, the review may be closed.

This initial review is the first step in determining a waiver setting's compliance. The focus is on the setting's current physical characteristics and the location contributing to community integration and people's rights. This review will identify any potential for heightened scrutiny and/or characteristics that may be potentially institutional and/or isolating in nature. All settings must also comply with the Licensing Administrative Code, if applicable.

Once the DD Section approves the setting, full compliance will be addressed through the person-centered planning process for each person on an initial and annual basis, speaking to the person's individual experiences.

Heightened Scrutiny

When a provider requests to enroll or add a setting that may fall under one of the three prongs below that will trigger the need for heightened scrutiny the DD Section will utilize a setting assessment tool to identify any institutional characteristics and ensures all regulations are evaluated. The assessment tool is completed onsite for each setting by the DD Section using observation and discussion with individuals, guardians, and provider staff. DD Section will work with the providers to complete the assessment tool and identify any areas of noncompliance, remediation efforts, and timelines for completion.

The three prongs include:

1) Settings in a publicly or privately-operated facility that provides inpatient institutional treatment;
2) Settings in a building on the grounds of, adjacent to, a public institution;
3) Settings with the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Providers will be given time to implement remediation efforts for any noncompliance identified. Once the provider informs the DD Section that they have implemented the necessary remediation efforts they will be required to submit an evidence package to the DD Section for review. The DD Section will review the evidence package, conduct a site visit, and gather feedback with individuals/legal decision makers to confirm remediation and compliance. The feedback will be gathered from individuals/legal decision makers in person or over the phone by the DD Section.

Once this process is complete, the information along with the information submitted in the evidence package will be reviewed by an internal HCBS settings committee. The committee will be comprised of a representative from the State's Aging Services Section, Developmental Disabilities Section, Medical Services Unit, and the State Risk Manager.

The committee will decide if the setting:

a) Has successfully refuted the presumptively and now fully complies;
b) With additional changes will fully comply; or
c) Does not/cannot meet HCB settings requirements.

If it is determined that the setting has provided enough evidence that they fully comply the evidence package will be submitted for public comment for 30 days. After the public comment period, it will be submitted to CMS to see if they concur.

If a decision is made that the provider cannot meet the regulations, they will be issued a denial for that setting and a transition plan will be developed with the individual(s) and their team to assist with relocation efforts to a setting that complies. If any relocation of individuals is needed, the person-centered planning process will be followed.

Assuring On-going Compliance

Provider Responsibilities

- Complete a self-assessment initially and annually. The self-assessment is completed with individuals and information gathered is used as part of the person-centered service planning. The self-assessment captures individual experiences such as if the individual feels their privacy is respected, are they happy with where they live, what changes they want in their life, etc.
- Develop and implement agency policies and procedures that are aligned with the regulation.
- Implement person-centered service planning practices and develop service plans according to regulations. Person-centered practices encourage the individual to direct their supports and services; make informed choices; participate in the community; and live independently as possible.
- Achieve accreditation initially and ongoing from a department recognized national accreditation organization.
- Provide initial and annual training on the regulations to staff who are responsible to monitor service delivery.

DD Program Manager Responsibilities

- Assess and monitor the physical environment of the individual's home and day program setting where waiver services are provided.
- Assist individuals in exploring and making choices in service options, supports, and locations.
- Participate in the individual's person-centered service planning and approve service plans.
- Monitor service satisfaction and service plan implementation.

DD Section Responsibilities

- Assess and develop a Statewide Transition Plan to describe how programs meet the regulations and how to remediate areas that don't comply. The Statewide Transition Plan describes how the state will achieve and maintain compliance with the HCBS Settings Regulations.
- Conduct an on-site survey at provider service locations.
- Review provider policies and procedures ensuring that they align with the regulation.
- Conduct a case file review process to verify on-going compliance.
- Provide initial and annual training for DD Program Managers.
- Provide initial training for new providers.

For detailed information on this section, refer to the DHHS website: https://www.hhs.nd.gov/human-services/hcbs.

SECTION VIII - SERVICE PLANNING

The North Dakota DD Section is committed to ensuring that all individuals are afforded the opportunity to lead and/or participate in developing their service plan. The plan contains a section listing services, which is completed and authorized by the DDPM for payment of DD funded services.

The provider and the individual and/or legal decision maker are responsible for the general day-to-day monitoring and implementation of the service plan. DDPMs are responsible for ensuring the plan is developed in accordance with applicable policies and procedures, overseeing service plan implementation to ensure that services meet individual needs and goals, settings are appropriately integrated in the community and meet all federal requirements, backup plans are effective, individuals exercise their choice of provider, and health services identified in the service plan are accessible.

As part of the quality enhancement review (QER) process, DDPMs conduct face-to-face visits with individuals every ninety (90) days if receiving a Traditional IID/DD HCBS Waiver service and once a year if receiving an ICF/IID service to assess individual satisfaction and the appropriateness of the amount and frequency of service provision, discuss progress towards the individual's achievement of service outcomes defined in the service plan, and review any substantiated abuse or neglect claims. DDPMs will work with providers to resolve any problems that are identified. Issues that cannot be resolved by providers are reported to the Region al DD Program Administrator for remediation.

An Individual Service Plan (ISP) authorizing services is required for all provider managed, QSP and self-directed services. The Department is not financially liable for services prior to the effective date.

The individual's team must meet initially, annually, and as needed to discuss the individual's needs and identify which services are most appropriate to meet the individual's health and safety. The DDPM is responsible for entering the ISP information in the OSP.

For detailed information on this section, refer to the DHHS website:
https://www.hhs.nd.gov/dd/information-dd-licensed-providers

SECTION IX – STANDARIZED ASSESSMENTS FOR RESOURCE ALLOCATION

An assessment is necessary to determine funding levels for individuals who are eligible for DD Services and choose one of the following services:

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (including individuals residing at Life Skills and Transition Center (LSTC),
- Residential Habilitation,
- Independent Habilitation,
- Day Habilitation,
- Prevocational Services,
- Small Group Employment, and/or
- Individual Employment.

Individuals who qualify for the above services are required to have a Support Intensity Scale (SIS) assessment if 16 or older or an Inventory for Individual and Agency Planning (ICAP) assessment for individuals under 16 years old. All assessments will be completed by a third-party vendor who is awarded a contract via a Request for Proposal (RFP) as directed by procurement policy.

The initial assessment will be completed within 90 days or at the time there are sufficient qualified responders of the individual beginning a qualified service. A reassessment of individual needs using the standardized assessment tool must be completed every thirty-six (36) months for an individual aged sixteen (16) or older, or every twelve (12) months for an individual under age sixteen (16).

If a major life-changing event occurs prior to the reassessment date, an individual or their authorized representative, or a provider organization may file a written request for an out of sequence reassessment to the appropriate regional service center. An out of sequence reassessment will reset the assessment effective date.

An individual or their authorized representative may request a reconsideration and/or appeal of the assessment if it is thought that there is an error in the information provided to complete the assessment, or if the procedures were not adhered to which could affect the assessment hours.

Individuals who are private paying for authorized services will not be required to participate in the assessment process. The individual's team will determine the number of staffing hours wanted to meet the individual's needs. The provider will use the rates identified in the rate matrix to determine the rate that the individual will be responsible to pay the provider.

To view the assessment policy, go to https://www.hhs.nd.gov/information-dd-licensed-providers.

SECTION X - AUTHORIZATION OF SERVICES

Individual Budget Amount (IBA)/service authorizations are required for all provider managed, QSP and self-directed services (see Table 3: Authorization Period). The Department is not financially liable for services prior to the effective date. In cases where an individual receives a service prior to the completion of the initial standardized assessment, the assessment score hours authorized for the individual shall apply from the first date the individual was authorized for that service.

Residential Habilitation, Independent Habilitation, Day Habilitation, Prevocational Services, Individual Employment, Small Group Employment, and Intermediate Care Facilities

- The assessment score will be multiplied by a formula based on the selected service. This will provide the team the number of service hours per month.
- If the team determines that the assessment score hours are not adequate for the individual, the team will need to review the outlier policy. If the individual meets the criteria in the policy, the team will need to complete the outlier request form (SFN 1835). If requesting an Outlier for Individual Employment Supports the team will need to complete the outlier request form (SFN 1853).
- The DD Section will review all outlier requests and communicate its final decision to the DDPA who will inform the team of the decision.
- All IBA/service authorization templates (excluding QSP services) are available on the Therap system.

To view the multiplier calculator, outlier and assessment policy, go to https://www.hhs.nd.gov/information-dd-licensed-providers.

In-Home Supports, Parenting Supports, Extended Home Health Care (EHHC)

- The DDPM uses a service application form instead of the assessment tool to determine the amount and frequency of these services, not to exceed the limits established in the Traditional Waiver.
- The individual, family and DDPM will complete the *In-Home Support Application* annually which may include information on the individual's behavioral status, stress upon the family, and type and frequency of service required.

Respite

- The family, DDPM and other team members will discuss the needs of the individual and determine the chosen service delivery method(s). The DDPM will complete the service authorization based on the service delivery method(s) identified by the team.

Community Transition Services

- The individual, family, and DDPM will complete the *Transitional Budget Form* (SFN 1862) with necessary signatures.
- The Regional Staff will submit the form to the DD State Office for prior approval. This form serves as the pre-authorization for this service.

Self-Directed Supports

- Individuals have budget authority (authority to direct allotted funds) for all self-directed service options. Their financial management responsibilities include scheduling services, requiring additional staff qualifications, recommending a service provider, substituting staff members, authorizing payments for goods and services, reviewing and approving provider invoices for services rendered, and determining staff wages. Individuals are free to select a wage rate above the established wage limits established by the State, but they may not reallocate funds assigned to each service. To assist with financial management, each individual is assigned a Fiscal Agent.

Adult Foster Care (AFC), Adult Foster Care (AFC) Respite, & Homemaker

- The authorized units for these services will be based the assessed need of the individual, the time frame in which the service can be provided, the maximum amount of service authorized, the tasks the QSP is authorized to provide, and the global and individual-specific endorsements required of the QSP. If a service is provided by multiple QSPs who meet the required endorsements, only one SFN 1810 detailing each provider's share of service units should be completed. This form is available online for download at https://www.nd.gov/eforms/Doc/sfn01810.pdf.

Infant Development

- The family, DDPM and other team members will discuss the needs of the individual and determine the frequency for each of the following: evaluation\assessment, home visit, consultations, and IFSP development. The DDPM will complete the service authorization based on the frequency identified by the team.

Personal Care

- The authorization process and related forms for Personal Care Services for an individual receiving this service through the DD Section can be found in the Personal Care Manual, Chapter 535.05 available at http://www.nd.gov/dhs/policymanuals/53505/53505.htm.

Section 11 Services

- The DD Residential and Vocational Administrator works with the DD regional human service center program administrator biennially to identify individuals eligible for the service. The DD Section contracts with Section 11 providers, based on individual need. No standard service authorization forms exist for Section 11 residential and employment services.

Appeals

1) An individual or individual authorized representative may appeal a denial, reduction, or termination of services. An appeal must be made within thirty days of the date of the notice of the denial, reduction, or termination. The individual or individual authorized representative shall submit the request for an appeal and hearing under North Dakota Century Code chapter 28-32 and chapter 75-01-03 to the appeals supervisor for the department of human services.

2) An individual or individual authorized representative may request an informal review within ten days of the date of the notice. A request for an informal review does not change the time within which the request for an appeal hearing must be filed.

For detailed information on appeals, refer to the DD Bookshelf: http://www.nd.gov/dhs/policymanuals/816/816.htm, select "PI's/Outstanding PI's" on the left-hand side.

Table 3: Authorization Period

Service	Individual Service Authorization Period
AFC, AFC Respite, Homemaker, Personal Care	Up to 6 months
Residential Habilitation, Independent Habilitation, Day Habilitation, Prevocational Services, Individual Employment, Small Group Employment, and Intermediate Care Facilities	Up to 12 months
In-Home Supports, Parenting Supports, EHHC	Up to 3 months*
Infant Development	Up to 6 months
Self-Directed Services	Up to 3 months*
Community Transition Services	Up to 90 days**
Respite	Up to 12 months***
Authorization period must end on March 31, June 30, September 30, and December 31. These cannot exceed 3 months.** * 90 days from being screened to the waiver** *****Cannot cross State Fiscal Year (July 1- June 30)**	

SECTION XI - RATES & BILLING GUIDANCE

Rates

The DD Section will issue rate guidelines and matrix annually. Rate guidelines and NDAC are utilized by providers in developing and managing annual budgets.

At the completion of the state fiscal year (June 30), the DD Section will send notification to provider agencies with ICF/IID services. ICF/ID provider agencies are required to complete a statement of cost on the state identified forms and submit additional supporting documentation to determine the Upper Payment Limitation as required by Social Security Act section 1902(a)(30)(A).

For detailed information on this section, refer to the "***Rate Guidelines*" - Appendix B**.

Residential Habilitation

This service is paid on a daily basis. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support vacancy factor and administrative costs. The "vacancy factor" is intended to cover costs when an individual is no longer in the setting with no intent to return.

a. Night staff - The assessment score hours indicate the level of habilitative hours a person needs, including awake night hours. Sleep night hours are not considered habilitative and therefore a percentage was included in the program support component of the rate to account for sleep night hours.

b. Room and board costs that the participant pays to the DD licensed provider are subject to the following limitations:
    1) Charges to individuals must not be greater than the individual's Supplemental Security Income (SSI) less a predetermined amount for personal incidental expenses, plus the average dollar value of Supplemental Nutrition Assistance Program (SNAP) benefits received by the individual. Personal incidental expenses are valued at one hundred thirty-five dollars for group-home individuals.
    2) For residential units or individuals receiving rental assistance, the governmental unit providing the subsidy must establish the room charges.
        Room and board rates must reflect the average dollar value of any energy assistance program benefits, if offered.

c. 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 away from the setting to ensure stability and continuity of staffing up to thirty calendar days per year per participant.
        1) If a participant has utilized all allowed retainer days (30 per calendar year), the provider may bill the participant privately for additional retainer days. The provider must have a policy in place to address this, and this policy must be reviewed with participants on admission and on an annual basis. The rate for

these additional days must be equal or less than the participants' established retainer rate.

d. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
    1) Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Intermediate Care Facility (ICF/IID)

a. This service is paid on a daily basis. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support, administrative, vacancy factor, and room and board costs. The "vacancy factor" is intended to cover costs when an individual is no longer in the setting with no intent to return.

b. Providers may bill for 30 therapeutic absence days in a calendar year and up to 15 absence days for hospitalization per occurrence.

c. Personal incidental expenses are valued at one hundred thirty-five dollars for ICF individuals.

d. The Provider may request an ICF/IID Property Add On, for facilities newly acquired or built after January 1, 2010. The calculation will remove 1.9% of the room and board component from the rate matrix and the allowable expense for depreciation and interest will be calculated into the rate.

The provider will need to request approval of a project prior to any new facilities. The DD Section will review the project proposal to determine several factors:

1. Need within the state as it relates to the Departments approved budget and consumer population.
2. Specifications of the facility are reasonable in relation to size and design.
3. Upon completion of the project, the provider must submit the final costs of the project, bank amortization of the principle and interest costs for the life of the loan, and number of years for the depreciation.
4. The request is only submitted initially and will be included in the Individual Budget Amount (IBA) with the admission and renewal of individuals to the qualifying location.

e. ICF/IID Provider Assessment Tax, the quarterly rate may not exceed a rate calculated by the Department of Human Services as an annual aggregate of gross revenues as of 12/31 of the preceding year for all ICF/IID multiplied by 1-1/2 percent and divided by the licensed beds as of 12/31 of the preceding year. This will be included in the Individual Budget Amount (IBA) with the admission and renewal of individuals to the qualifying location.

f. ICF/IID Medically Involved or Medically Intensive Rate, if an individual meets criteria outlined in policy and the condition poses an additional program support cost to the ICF/IID,

the provider may request an enhanced rate. The team may be included in the completion of the request, but is not required. The provider is responsible for completing this request and it does not automatically renew.

Independent Habilitation

a. This service is paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.
b. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
    1. Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Day Habilitation, Prevocational Services, Individual and Small Group Supported Employment, and Parenting Support

a. These services are paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.

Adult Foster Care (AFC)

a. This service is paid on a daily rate. This service also includes a component of respite paid on a 15-minute unit.
b. AFC rates are preauthorized by Department staff through an individual authorization.

In-Home Supports

a. This service is paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.
b. The individual, family and DDPM will complete the In-Home Supports Application annually which may include information on the individual's behavioral status, stress upon the family, and type and frequency of service required not to exceed the limits established in the Traditional IID/DD HCBS Waiver.
c. Each individual will receive an individualized authorization.
d. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
    1) Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Respite

a. These services are paid on a 15-minute unit. The direct support rates are identified in the rate matrix. Components of the rate include hourly direct care staff wages, relief staff, employment related expenses, program support and administrative costs. No absence factor is included.
b. Each individual will receive an individualized authorization.
c. In accordance with Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)), states' Medicaid programs are permitted to provide home-and community- based services (HCBS) to individuals in acute care hospital setting.
    1) Refer to page 36 on this document for further guidance on services in acute care hospital setting.

Family Care Option, Parenting Supports, and Extended Home Health Care

a. The individual, family and DDPM meet annually to discuss information on the individual's behavioral status, stress upon the family, and type and frequency of service required not exceeding the limits established in the Traditional IID/DD HCBS Waiver.
b. Each individual will receive an individualized authorization.

Community Transition Services

a. Services are paid based on the cost of goods and/or services.
b. Each individual will receive an individualized authorization.

Homemaker Services

a. This service is paid on 15-minute units.
b. Homemaker rates are preauthorized by Department staff through an individual authorization.

Infant Development Services

a. This service is authorized on a fee-for-service basis. Services include four pay points.
b. Infant Development services are preauthorized by Department staff through an individual authorization in Therap.

Self-Directed Supports

a. Equipment & Supplies, Environmental Modification, Behavioral Consultation, Self-Directed In-Home Supports, Self-Directed Respite, and Remote Monitoring are considered Self-Directed Services within the Traditional IID/DD HCBS Waiver.
b. Services are paid based on the cost of goods and/or services.

c. Families who choose to self-direct services must enroll with the Department's chosen Fiscal Agent vendor. After enrollment has been approved, families will be required to submit appropriate documentation for reimbursement of goods and/or services to the Fiscal Agent. The appropriate documentation may include a time sheet, identifying the service date, amount, and frequency; or a receipt of goods purchased, identifying date of purchase and amount.
d. Budgets are preauthorized by Department staff through an individual authorization in Therap.
e. The individual, family and DDPM meet annually to discuss information on the individual's behavioral status, stress upon the family, and type and frequency of service required not exceeding the limits established in the Traditional IID/DD HCBS Waiver.
f. The Fiscal Agent will submit claims identifying the actual amount paid within the authorization limits and include the date or date range for the service or item to the HE MMIS. The amount claimed in HE MMIS must reflect what was paid to families and vendors within the individual authorization.

Additional considerations for Residential Habitation and ICF/IID services

Attending Physician Form
Federal regulation 42 CFR 456.360 requires that a physician certify the need for services in an intermediate care facility for each eligible recipient of Medical Assistance upon admission and at least every 365 days (may not exceed 365 days). This is to certify that the recipient named below requires, on an inpatient basis, ICF/IID level of care. SFN 1812 must be given to the certifying physician to sign at ICF/IID individual's annual exams certifying the need for the ICF/IID level of care. The form can be found here: https://www.nd.gov/eforms/Doc/sfn01812.pdf

Developmental Disabilities Providers are required to submit institutional claims utilizing the certifying physician information in the claim under the attending physician section. This information is to be included on the attending physician portion of the institutional claim in HE MMIS. If this information is not included in the attending physician portion of the institutional claim, the claim will be denied due to missing attending physician information.

Base Staffing Rate
New provider-owned group homes receive a base-staffing rate until fully occupied, or for three (3) months, whichever comes first. A base-staffing rate is based on minimum staffing levels identified in NDAC 75-04-05 and is effective as of the facility's date of licensure.

Non-school Days for 16-21 Add-on
When an individual is between the ages of 16 and 21 prior to the start of the school year, is eligible for Individuals with Disabilities Education Act (IDEA) and resides in residential habilitation or intermediate care facility for individuals with intellectual disabilities (ICF/IID), the individual will qualify for additional hours to account for non-school days. The DDPM will select the option to add additional staffing relating to non-school days in the web-based case management system worksheet process.

Medical Acuity Payment Tiers

Payment rates for Residential Habilitation, Day Habilitation, Prevocational Services, and Small Group Employment Support, may include a component for ongoing nursing support, higher credentialed staff, and increased programmatic oversight. There are 3 additional medical acuity tiers for the rate. The development of these tiers included a program support component to represent the hours of nursing relative to the hours of direct support professionals at each acuity tier, then adjusted this ratio to account for higher relative wages for CNAs and RNs based on 2018 Bureau of Labor Statistics Data.

Private Pay

"Private pay" refers to paying for services or goods directly out-of-pocket, using personal funds rather than relying on insurance, government programs, or other forms of financial assistance. DD services may be provided to individuals who do not receive Medicaid and will private pay for those services. The rate for those private pay DD services must be at or above the established Medicaid rates.

Billing Guidance

To be eligible for reimbursement, providers must meet the following requirements:

Summary of Requirements
Ensure the individual is eligible for the service (See Sections II.A and IV.A), and has a PCSP on file with the DD Section
Hold a valid provider license, if required (See Section VII), and/or be enrolled as a Qualified Service Provider
Have a current valid Medicaid *Agreement and Provider Addendum* agreement with the DD Section authorizing the payment
Use the accounting system prescribed by the DD Section
Enrolled in Health Enterprise Medicaid Management Information System (HE MMIS)
Participate in the program audit and utilization review process, and comply with documentation requirements established by the DD Section
A provider must obtain approval from the DD Section for additional square footage, increased occupancy/capacity, etc. for DD service reimbursed by the Department.

A provider must enroll in HE MMIS and comply with the requirement in Table 4 to submit a claim. During enrollment, a provider must create a username and password to be utilized when logging into the HE MMIS to submit claims. Once a provider is enrolled in HE MMIS, the provider will receive a provider number.

For detailed information on this section, refer to the "***HE MMIS Enrollment and Claim Submission" -*** **Appendix C**.

SECTION XII – DD SECTION INFORMATION

For further details or questions, contact the DD Section at:

ND Department of Health and Human Services
Developmental Disabilities Section
1237 W Divide Ave Ste 1A
Bismarck ND 58501-1208
Phone: (701)328-8930
Toll Free: 1-800-755-8529
Website: https://www.hhs.nd.gov/dd

SECTION XIII – SERVICE DESCRIPTIONS - APPENDIX A

TRADITIONAL IID/DD HCBS WAIVER SERVICE DESCRIPTIONS

DAY HABILITATION

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** YES
Medical Acuity Ties: YES	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Day Habilitation services are scheduled activities, formalized training, and staff supports typically provided in a non-residential setting to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities should focus on improving a participant's sensorimotor, cognitive, communication and social interaction skills. The goal of this service is to enable the participant to attain or maintain his or her maximum physical, intellectual, emotional, and social functional level. Day Habilitation services should facilitate, and foster community participation as indicated in each participant's person-centered service plan.

Day Habilitation is coordinated with any needed therapies in the participant's person-centered plan, such as physical, occupational, or speech therapy.

Day habilitation services may also be used to provide retirement activities. As some participants age, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. For participants with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills.

Location

Day Habilitation is furnished in a non-residential setting, separate from the participant's private residence or other residential living arrangement. However, this service may be furnished in a residence if the participant's needs are documented in the participant's person-centered service plan.

This service shall be provided in a non-residential setting, separate from the participant's private residence or other residential living arrangement. However, this service may be furnished in a residence if the participant's needs are documented in the participant's person-centered service plan.

Transportation

Rates for Day Habilitation may include transportation costs to access program related activities in the community. Transportation does not include travel between the individual's home and the day habilitation program site. Any transportation provided to an individual as a part of the rate is not billable as a discrete service and cannot duplicate transportation provided under any other service in the waiver.

Medial Acuity Tiers

Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Day Habilitation rate. These tiers are based on the participant's assessed medical needs.

Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

A nurse assessment and care plan are required for the medical acuity tiers. The participant's person-centered service plan must address medical needs. Nursing services must be within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota.

For additional information see the Medical Acuity Tier Rate Add On policy

SERVICE LIMITS

- An individual may be enrolled concurrently in Day Habilitation per DD Section policy.
- Day Habilitation and hours of employment in Individual Employment Support, Small Group Employment Support and Prevocational Services combined cannot exceed 40 authorized hours per week. However, billing for services may not be duplicated for a time period (i.e. billed for both for 1 to 5 pm on April 1).
- Day Habilitation shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, or Homemaker services.
- This service will not be authorized, nor payment made, for individuals who are eligible for services under the Individuals with Disabilities Education Act.
- This service may not duplicate services provided under any other service in the waiver.
- Day Habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purposes of producing goods or performing services).
- Day Habilitation cannot be authorized on the individual service plan with Family Care Option.
- The service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

INDPENDENT HABILITATION

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: YES	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: YES	**SIS/ICAP:** YES
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Independent Habilitation services are formalized training and staff supports provided for fewer than 24 hours per day based upon the participants needs. Independent Habilitation is typically not delivered on a daily basis.. 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.

Location

Independent Habilitation may be provided in community settings, residential settings leased, owned, or controlled by the provider agency, or in a private residence, provided that such services do not duplicate services furnished to a participant.

Multiple participants living in a single or a shared private residence are eligible for this service.

Eligible participants must not be living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The participant may be living with other individuals who may or may not be receiving waiver services.

Virtual Supports

This 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. (See virtual supports policy for additional guidance)

Independent Habilitation is to provide support for conditions specifically related to IID/DD.

SERVICE LIMITS

- Payment for this service will not be made for routine care and supervision that is normally provided by the family for services furnished to a minor by the child's parent, adoptive parents, guardian, or step-parent.
- Payment for this service will not be made to others living in the same residence as the participant.

- Independent Habilitation shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
- Independent Habilitation service cannot be authorized on the individual service plan with In-Home Supports, Residential Habilitation, Adult Foster Care, Homemaker, Family Care Option, Parenting Support, Extended Home Health Care, Behavioral Consultation, Respite, or Medicaid State Plan Personal Care services.
- Independent Habilitation service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Independent Habilitation service payment does not include room and board or cost of facility maintenance and upkeep.
- Independent Habilitation service does not include payment for non-medical transportation costs.
- Independent Habilitation service cannot duplicate any other service in the waiver.

INDIVIDUAL EMPLOYMENT SUPPORT

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: YES	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** YES
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Individual Employment Support is long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting or self-employment. This service is designed for participants who need intensive ongoing support to perform in a work setting. Service includes on- or off-the-job employment-related support for participants needing intervention to assist them in obtaining or maintaining employment, in accordance with their person-centered service plan. Supports are provided on an individual basis. Participants are paid by the employer at or above minimum wage.

Individual Employment Support services are to provide support for conditions specifically related to IID/DD.

Transportation

Transportation from a participant's residence to their workplace may be included in authorized services hours when a participant needs it as a support intervention for the participant to maintain employment. It is not allowed as a substitute for personal, public, or generic transportation, is not billable as a discrete service, and cannot duplicate any transportation under any other service in this waiver or Medicaid State Plan.

Virtual Supports

This 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. (See Virtual Support Policy for additional information)

SERVICE LIMITS

- An individual may be enrolled concurrently in Individual Employment Support, Day Habilitation, Prevocational services, and Small Group Employment Support services and are subject to limitations stipulated in DD Section policy. Billing for such services may not be duplicated in a time period (e.g., billed for more than one service for 1:00 to 5:00 p.m. on April1).
- Individual Employment Support services direct intervention time can only be provided to one participant at a time.
- Hours authorized in Day Habilitation, Individual Employment Support, Prevocational Services, and Small Group Employment Support services may not exceed 40 cumulative hours per week per participant.
- Individual Employment Support shall not be furnished or billed at the same time of day as at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, Respite, or Homemaker services.
- Individual Employment Support services do not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- Individual Employment Support does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.
- Individual Employment Support services does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Individual Employment Support cannot duplicate services provided under any other service in the waiver.
- Individual Employment cannot be authorized on the individual service plan with Family Care Option.
- This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- Payments that are passed through to users of supported employment services.

PREVOCATIONAL SERVICES

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO

EVV Required: NO	**SIS/ICAP:** YES
Medical Acuity Tiers: YES	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Prevocational Services are formalized training, experiences, and staff supports designed to prepare participants for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services may include training in effective communication within a work setting, workplace conduct and attire, following directions, attending to tasks, problem solving, and workplace safety. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the participant's person-centered service plan.

Prevocational Services is to provide support for conditions specifically related to IID/DD.

Providers must, in consultation with each participant, develop employment outcomes that are consistent with the participant's goals/outcomes in their person-centered service plan that outlines a pathway for transitioning to integrated employment. The person-centered plans must be updated annually, and documentation must include each participant's progress toward completion of prevocational training.

Individuals participating in this service may be compensated in accordance with applicable federal laws and regulations.

Participation in Prevocational Services is not a required prerequisite for Individual Employment or Small Group Employment services.

Medical Acuity Tiers

Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Prevocational Services rate. These tiers are based on the participant's assessed medical needs.

Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

A nurse assessment and care plan are required for the medical acuity tiers. The participant's person-centered service plan must address medical needs. Nursing services must be within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota. For additional information see the Medical Acuity Tier Rate Add On policy

SERVICE LIMITS

- Prevocational Services are available to those receiving Day Habilitation, Individual Employment Support and Small Group Employment Support is subject to limitations stipulated in DD Section policy. Billing for services may not be duplicated in a time period (e.g. billed for more than one service for 1:00 p.m. to 5:00 p.m. on April 1)

- Hours authorized in Day Habilitation, Individual Employment Support, Small Group Employment, and Prevocational Services may not exceed 40 cumulative hours per week per participant.
- Prevocational Services not be furnished at the same time as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, Respite, or Homemaker services.
- Prevocational Services does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.
- A participant's need and desire for continued Prevocational Services shall be evaluated every twelve (12) months, or more frequently if requested by the participant and/or legal decision maker
- The Department will review the active progress made during the prior year on increasing work skills, time on tasks, or other job preparedness objectives. The Developmental Disabilities Program Administrator (DDPA) may approve two additional 12 months of prevocational training with submission of employment outcomes that are consistent with the participant's goals/outcomes in their person-centered service plan. A participant who requests remaining in the service beyond the two additional approvals from the DDPA (36 months) must receive approval from the DD Section.
- Transportation does not include travel between the participant's home and the Prevocational Services program site.
- Any transportation provided to a participant as a part of the rate is not billable as a discrete service and cannot duplicate transportation provided under any other service in this waiver or Medicaid State Plan.
- Prevocational Service may not duplicate services provided under any other service in the waiver.
- Prevocational Services cannot be authorized on the individual service plan with Family Care Option.

SMALL GROUP EMPLOYMENT SUPPORT

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** YES
Medical Acuity Tiers: YES	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Small Group Employment Support services are long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting. Service include on- or off-the-job employment-related support for small group participants needing intervention to assist them in obtaining and maintaining employment as a group, in accordance with their person-centered service plan. Supports are provided to groups of two (2) to eight (8) employed participants.

The outcome of this service is sustained paid employment and work experience leading to further career development and individual intergraded community -based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Participants are paid by the employer at or above minimum wage.

Small Group Employment Support is to provide support for conditions specifically related to IID/DD.

Location

Assist participants in paid employment in an integrated setting. This service does not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Small Group Employment cannot occur in a DD licensed facility

Transportation

Transportation costs from a participant's residence to their workplace may be included in the authorized service hours when a participant needs it as a support intervention for the participant to maintain employment. It is not allowed as a substitute for personal, public, or generic transportation, is not billable as a discrete service, and cannot duplicate any transportation under any other service in this waiver or Medicaid State Plan.

Medical Acuity Tiers

Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Small Group Employment Support rate. These tiers are based on the participant's assessed medical needs.

Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

A nurse assessment and care plan are required for the medical acuity tiers. The participant's person-centered service plan must address medical needs. Nursing services must be within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota. For additional information see the Medical Acuity Tier Rate Add On policy

SERVICE LIMITS

- Group size is limited to no fewer than two (2) and no more than eight (8) participants.
- Small Group Employment Support service may not be used to support a self-employed participant.
- Small Group Employment Support is available to those receiving Day Habilitation, Prevocational services and Individual Employment Support services are subject to limitations stipulated in the DD Section policy. Billing for services may not be duplicated for a time period (i.e. billed for both for 1 to 5 pm on April 1).
- Hours authorized in Day Habilitation, Individual Employment Support, Prevocational and Small Group Employment Support services cannot exceed 40 hours per week.
- This service does not include facility-based , or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Small Group Employment cannot occur in a DD licensed facility
- Small Group Employment Support service shall not be furnished or billed at the same time of day as other services that provides direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, Respite, or Homemaker services.

- Small Group Employment Support service does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
- Small Group Employment Support service may not duplicate under any other service in the waiver.
- Small Group Employment Support service does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.
- Small Group Employment Support cannot be authorized on the individual service plan with Family Care Option.

HOMEMAKER

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Qualified Service Provider (QSP)
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: YES	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

The purpose of Homemaker services is to complete tasks that an individual with a disability is not able to complete in order to maintain that individual's home such as housework, meal preparation, laundry, shopping, communication, and managing money.

Homemaker services are offered to participants living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks. If the participant lives with a capable person or provider and requests this service, the assessment must identify why the capable person or provider cannot perform the task.

Homemaker Services is to provide support for conditions specifically related to IID/DD.

SERVICE LIMITS

- Transportation or escorting the client is not an allowable task under Homemaker services.
- The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action.
- The cap is different for agency providers than individual providers as agency providers are allowed an administrative reimbursement. This cap may be increased as determined by legislative action. The DDPM informs a participant of the service cap.
- Homemaker services cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, Family Care Option, or Adult Foster Care.
- Homemaker services cannot be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, Behavioral Consultation, Parenting Support, Extended Home Health Care, In-Home Supports, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Homemaker services may not duplicate services provided under any other service in the waiver.

RESIDENTIAL HABILITATION

Provider Managed: YES	**Self-directed:** NO
Service unit: daily rate	**Provider type:** DD Licensed Provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** YES
EVV Required: NO	**SIS/ICAP:** YES
Medical Acuity Tiers: YES	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Residential Habilitation consists of an integrated array of individually designed training activities, assistance and supervision.

Residential Habilitation is formalized training and supports provide to participants who require some level of ongoing daily support. Residential Habilitation service is designed to assist with and develop self-help, socialization, community inclusion, transportation, and adaptive skills that assist the participant to reside in the most integrated setting appropriate to their needs.

Residential Habilitation service is used to assist with self-care and/or transfer a skill from the direct care staff to the participant.

Residential Habilitation service is to provide support for conditions specifically related to IID/DD.

Location

Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence.

Eligible participants must not be living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The participant may be living with other individuals who may or may not be receiving waiver services.

Medical Acuity Tiers

Participants who require ongoing nursing support may be eligible for a higher medical acuity level. There are 3 additional medical acuity tiers for the Residential Habilitation rate. These tiers are based on the participant's assessed medical needs.

Staff who provide services in the medical acuity tiers are required to have a current Certified Nursing Assistant (CNA) certification or equivalent or higher.

A nurse assessment and care plan are required for the medical acuity tiers. The participant's person-centered service plan must address medical needs. Nursing services must be within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the

supervision of a RN licensed to practice in the state North Dakota. For additional information see the Medical Acuity Tier Rate Add On policy

Acute Care Hospital

In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, Residential Habilitation may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law. (See Provider Manual for additional guidance)

SERVICE LIMITS

- Payment for this service will not be made for routine care and supervision that is normally provided by the family for services furnished to a minor by the child's parent, adoptive parents, guardian, or step-parent.
- Payment for this service will not be made to others living in the same residence as the participant.
- Residential Habilitation shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Residential Habilitation shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
- Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.
- Residential Habilitation service cannot be authorized on the individual service plan with In-Home Supports, Independent Habilitation, Adult Foster care, Homemaker, Parenting Support, Extended Home Health Care, Family Care Option, Behavior Consultation, Respite, or Medicaid State Plan Personal Care services.
- Residential Habilitation service cannot duplicate any other service in the waiver.
- Residential Habilitation rates do not include payment for non-medical transportation costs.
- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.

EXTENDED HOME HEALTH CARE (EHHC)

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider, Certified Home Health Care Provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: YES	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Extended Home Health Care provides skilled nursing tasks to eligible participants who have maximized the amount of service available under the Medicaid State Plan. A nurse assessment, nursing care plan, and an order

written by the participant's primary health care provider are required. The participant's person-centered service plan must address medical necessity.

Extended Home Health Care service is available only to participants living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.

Services are provided by a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN licensed to practice in the state North Dakota and must be within the scope of the State's Nurse Practice Act.

Extended Home Health Care (EHHC) is not intended to replace the care and support provided by the primary caregiver or to provide care on a 24- hour basis. Provision of EHHC will consider the daily responsibilities the primary caregiver(s) will have and the care they will provide; unpaid supports that are available; and other services that are provided or available to the participant and primary caregiver.

Extended Home Health Care service is to provide support for conditions specifically related to IID/DD.

SERVICE LIMITS

- This service may not provide care or supervision to others in the home e.g., siblings of eligible participant.
- This may not be provided in a group or facility- based setting.
- This service is not authorized when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP.
- This service cannot be provided by an individual living in the same home as the eligible participant.
- Extended Home Health Care service cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, Family Care Option (FCO), Homemaker, or Adult Foster Care (AFC).
- Extended Home Health Care service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Parenting Support, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, Infant Development, Respite or Individual Employment.
- Extended Home Health Care service cannot duplicate any other service in the waiver.
- This service cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.

ADULT FOSTER CARE (AFC)

Provider Managed: YES	**Self-directed:** NO
Service unit: Daily Rate (AFC) 15 min (AFC Respite)	**Provider type:** Qualified Service Provider (QSP)
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: ACC-NO AFC Respite- YES	**SIS/ICAP:** NO

Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Adult Foster Care (AFC) is provided to a participant for ADL's, IADL's and supportive services provided in a private home licensed to meet the specifications of AFC. Services include preparation of meals; general housekeeping; medication assistance; personal care assistance; and assistance to access the community, and social and leisure activities.

The total number of individuals who live in the home who are unrelated to the care provider cannot exceed four (4).

Non-medical transportation is a component of AFC and is included in the rate.

AFC is to provide support for conditions specifically related to IID/DD.

AFC Respite maybe be a component within this service.

SERVICE LIMITS

- AFC must be provided in a licensed AFC home. Services are provided to the extent permitted under state law.
- AFC cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, In-Home Supports, Family Care Option, EHHC, Homemaker services, Parenting Support, Equipment and Supplies, Environmental Modifications, Behavioral Consultation, or with Medicaid State Plan Personal Care services.
- The waiver service of Respite cannot be authorized on the individual service plan with AFC as there is a respite component to AFC.
- The participant pays for room and board costs which are not included in the AFC payment.
- This service will only be provided in an individual Qualified Service Provider (QSP) Licensed Adult Foster Care home.
- The cost of AFC is limited to a maximum monthly cap set by the Department or through legislative action.
- If the participant's needs cannot be met within the allowed rate, the DDPM explores other waiver service options with the participant, including institutional placement. The DDPM makes participants aware of the service cap.
- AFC shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- AAFC cannot duplicate any other service in the waiver.

BEHAVIORAL CONSULTATION

Provider Managed: NO	**Self-directed:** YES
Service unit: 15 minute	**Provider type:** • License ○ A current licensed ND Behavior Analyst, ND Registered Behavioral Analyst, ND Psychiatrist or Psychologist • Certificate

	○ A currently certified ND Behavior Modifications Specialists or QDDP employed not contracted by a licensed DD Provider.
Virtual Supports: YES	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Behavioral Consultation is a service provided to meet the excess disability related expenses associated with maintaining a participant in their primary caregiver's home and not covered through the Medicaid State Plan. The service provides expertise, training and technical assistance in natural environments (home, grocery store, community) to assist primary caregivers, and other natural supports to develop an intervention plan designed to address target behaviors. The behavior support plan is determined and written by the behavioral consultant with input from the participant's team and incorporated into the participant's person-centered service plan.

Allowable Activities covered are:

- Observing the participant to determine the needs;
- Assessing current interventions for effectiveness;
- Developing a written intervention plan which clearly delineates the interventions, activities, and expected outcomes to be carried out by family members, support staff, and natural supports in the intervention plan;
- Training of primary caregiver to implement the specific interventions/support techniques delineated in the intervention plan ;
- Observing, recording data and monitoring implementation of therapeutic interventions/support strategies;
- Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes;
- Providing training and technical assistance to primary caregiver(s) to instruct them on the implementation of the participant's intervention plan; and/or;
- Participating in team meetings.

Behavioral Consultation services are to provide support for conditions specifically related to IID/DD.

Virtual Supports

This 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. (See Virtual Support Policy for additional information)

SERVICE LIMITS

- Limitations are for the development and the evaluation of the plan and training of the primary caregiver.

- Behavioral Consultation service does not include implementation of the plan by the behavior consultants or training of the staff.
- Behavioral Consultation service excludes services provided through the Individual Education Plan (IEP).
- Behavioral Consultation service is limited to limited to $5,200 per participant per State Fiscal Year unless an exception is approved by the DHS/DDD to prevent imminent institutionalization. Given that this is a self-directed service the participant\legal decision maker must choose a service provider who meets Department set parameters of the provider's specifications of the service. The participant\legal decision maker chooses the appropriate provider dependent on the participant's budget and the provider rates.
- Behavioral Consultation service is not available for individuals receiving Residential Habilitation or Independent Rehabilitation as behavioral consultation is included as a professional service.
- Behavioral Consultation services cannot be provided in a foster care setting but may be authorized in the natural family home when the participant is present and the requirements above are met.
- Behavioral Consultation services cannot be authorized on the individual service plan with Infant Development.
- Behavioral Consultation service may not be provided in a clinical setting or a school.
- Behavior Consultation service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Extended Home Health Care, Parenting Support, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, Respite, or Individual Employment.
- Behavioral Consultation service may not duplicate any other service in the waiver.

ENVIRONMENTAL MODIFICATIONS

Provider Managed: NO	**Self-directed:** YES
Service unit: item	**Provider type: Vendor or Individual**
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Environmental Modifications service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid Sate Plan to maintain a participant living in their own home or in the home of their primary caregiver. A primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The home must be owned or rented by the participant or the participant's primary caregiver.

Environmental Modifications service consists of modifications made to a participant's primary home or vehicle. Home Modifications are age-appropriate physical modifications identified in the participant's plan of care developed by the participant's team, which are necessary to ensure the health, welfare, and safety of the participant or/and enable the participant to function with greater independence in the home, and without which,

the participant would require institutionalization. A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the participant.

An environmental modification provided to a participant must:

- relate specifically to and be primarily for the participant's disability;
- any modifications must be done primarily for the participant with the disability;
- not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
- and not be in the form of room and board or general maintenance.

Home Modifications

Environmental Modifications service covers purchases, installation, and as necessary, the repair of the following home modifications which are not covered under the Medicaid State Plan:

- Permanent ramps
- Permanent lifts, elevators, manual, or other electronic lifts,
- Modifications and/or additions to bathroom facilities
    - Shower modifications
    - Sink modifications
    - Bathtub modifications
    - Toilet modifications
    - Water faucet controls
- Improve access/ease of mobility, excluding locks,
    - Widening of doorways/hallways,
    - turnaround space modifications
    - floor coverings
- Specialized accessibility/safety adaptations/additions
    - Electrical wiring
    - Fire safety or other emergency adaptations
    - Windows modifications
    - Modifications to meet egress regulations if there are no other egress options available in the structure
    - Automatic door openers/doorbells
    - Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant.
    - Durable wall finishes
- Modifications and/or additions to kitchen facilities
    - Sink modifications
    - Water faucet controls
    - Counter/cupboard modifications

Vehicle Modifications

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community and are required by the participant's

plan of care. The installations of these items are included. The waiver participant or primary caregiver must own the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Covered Vehicle Modifications are:

- Door modifications
- Installation of raised roof or related alterations to existing raised roof system to increase head clearance
- Lifting devices
- Devices for securing wheelchairs or scooters
- Handrails and grab bars
- Seating modifications
- Lowering of the floor of the vehicle

Environmental Modification service is to provide support for conditions specifically related to IID/DD.

SERVICE LIMITS

- For Environmental Modification services the amount will not exceed $40,000 per participant for the duration of the waiver period. The authorization database will track the amount authorized and utilized to prevent over-expenditure.
- Requests for home modifications (environmental modification) anticipated to exceed $500, three estimates are required to determine the most cost-efficient material for the adaptation to meet the participant's needs. All other requests are reviewed on a case-by-case basis to determine if the request is reasonable and appropriate.
- Repair of items purchased through the waiver or purchased prior to waiver participation is covered, as long as the item is identified within this service definition, determined by the team and appropriate professional to be necessary, and the cost of the repair does not exceed the cost of purchasing a replacement piece of the item.
- Environmental Modification service cannot duplicate any other service in the waiver.

Home Modifications

- If the home is rented by the participant or the participant's primary caregiver, a written approval from the landlord of any modification must be submitted with the request.
- The base product and one repairs, not covered under the of warranty, of the home modification which is are cost efficient and continue to appropriately meets the needs of the participant will be covered.
- Home modifications are limited to remodels of an existing structure (home the participant is living in). Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- Home modifications will not be approved for new construction (building a new house) or unfinished area (i.e. basement).
- Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- Excluded are those adaptations or improvements to the home which are of general utility and are not of direct or remedial benefit to the individual.
- Home modifications purchased for exclusive use at the home school are not covered. Waiver funding will not be used to replace home modifications that have not been reasonably cared for and maintained. All services shall be provided in accordance with applicable State or local building codes.

Vehicle Modifications

- The cost of purchasing a vehicle with adaptations, service and maintenance contracts and extended warranties, are not covered. Adaptations for a vehicle purchased, rented, or leased for exclusive use at the school/home school are not covered.
- The base product and repairs, not covered under the warranty, of the vehicle modification which is are cost efficient and continue to appropriately meets the needs of the participant will be covered.
- Payment may not be made to adapt the vehicle modifications adapt the vehicle that are owned or lease by paid providers of waiver services.

EQUIPMENT AND SUPPLIES

Provider Managed: NO	**Self-directed:** YES
Service unit: item	**Provider type:** Vendor
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Equipment and Supplies service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a participant in their home. Equipment and Supplies enable a participant to remain in and be supported in their home, preventing or delaying unwanted out of home placement or imminent institutionalization. Individual needs identified through the planning process in the following areas can be addressed through the individual budget process.

Equipment and Supplies service covers purchases of the following which are not covered under the Medicaid State Plan:

- devices, controls, or appliances, specified in the participant's plan , that enable participants to increase their ability to perform activities of daily living (i.e. switches, grab devices, portable ramps, portable lifts);

- devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
- items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
- Assistive technology device means an application or software item, or piece of equipment, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.
- 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:
    - 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;
    - services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
    - services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
    - ongoing training and technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
    - ongoing training and technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.
- Personal Emergency Monitoring Response System is an electronic device or control that enables waiver participants to secure help in an emergency, be monitored to maintain health safety, or promote independence without paid staff. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep, and maintenance of devices/systems are provided;
- Specialized Medical supplies gloves, diapers, wipes, hospital bed, and nutritional supplements.

Equipment and Supplies service is to provide for conditions specifically related to IID/DD.

SERVICE LIMITS

- All equipment and supplies shall meet applicable standards of manufacture, design and installation.
- Equipment & Supplies and Remote Monitoring will be limited to $5,000 per participant per waiver year with a maximum of $25,000 per waiver period, unless an exception is approved by the DHHS/DD to prevent imminent institutionalization. The authorization database tracks the amount authorized and utilized to prevent over expenditure. A “waiver period” is year 1 through year 5 of the current approved waiver.
- Experimental or prohibited treatments are excluded. These include treatments not generally accepted by the medical community as effective and proven, not recognized by professional medical organizations as conforming to accepted medical practice, not approved by FDA or other requisite government body, are in clinical trials or further study or are rarely used, novel, or unknown and lack authoritative evidence of safety and efficacy.

- A written recommendation must be obtained by an appropriate professional and three separate trials of equipment, when appropriate, to ensure that the equipment will meet the needs of the participant prior to consideration for approval.
- Generic devices and items (e. g. tablets, computers, printers, ancillary items, exercise equipment, cell phones, home security systems) are not allowed.
- Nutritional supplements are only covered when they constitute 51% or more of nutritional intake to ensure that it is not duplicated under the Medicaid State Plan.
- Equipment and Supplies service cannot duplicate any other service in the waiver.

REMOTE MONITORING

Provider Managed: NO	**Self-directed:** YES
Service unit: Item • Equipment • Subscription	**Provider type:** Vendor
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Funds for this service may be accessed to meet the disability related expenses outlined in the service plan that are not covered through the Medicaid State Plan, that are necessary to avoid institutionalization and maintain a participant in their home. Remote Monitoring device enables a participant to remain in and be supported in their home, preventing, or delaying unwanted out of home placement or imminent institutionalization. The participant's needs identified through the person-centered planning process can be addressed through the participant's budget process.

Remote monitoring is a device or control for the participant that enables them to be located or monitored when there is a health and safety risk related to the participant's disability. The device needs to be approved by the person or legally responsible person, due process completed as necessary to ensure it is least restrictive and documented in the service plan. Primary caregiver, legal decision maker, and/or provider is responsible for device usage and associated applications related to the device.

The device will allow the participant to experience more independence in their daily schedule, increase inclusion with peers, and offer additional protection. Additionally, it will provide quicker response time in location of the participant resulting in a positive outcome of safety, protection, decreasing hospitalizations, and decreasing institutional care. When in the community settings, the participant will be able to be located when there is risk of health and safety and reduce reliance on paid staff supervision or assistance.

Participant and/or legal decision maker, along with the team members, will identify the appropriate device and document it within the participant's service plan prior to use. The participant's service plan must state the need for the remote

monitoring device due to health and safety risk(s) related to the participants disability prior to utilization, must have a plan in place of when to use the device, and what steps are being utilized to decrease risks. The participant's service plan must state the health and safety risks, the steps that have been taken in the past to ensure health and safety, and a back-up plan due to failure of the equipment. The service plan must include whether the participant is able to turn off the remote monitoring device if they choose to do so and the participant must be informed of the option and how to turn the device off. The informed consent will be obtained from the participant/legal decision maker when they sign the Service Plan.

The participant along with the primary Caregiver and/or legal decision maker will have ultimate authority on when device is needed for participant and who needs to be aware of the device being used. Remote Monitoring devices and activities are not permissible in bathrooms or bedrooms when participant's dignity and privacy is impacted. Devices can be placed in a location that may be secured by the participant, parent or legal decision maker as appropriate and can be either out of sight or visible depending on the participant's needs. A team meeting with the parent/legal decision maker, participant, and team members prior to the use of remote monitoring activities will act as a safeguard to ensure remote monitoring can meet the health and welfare needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion.

Remote Monitoring Service includes:

A) Equipment- purchase of the device.

B) Subscription-purchase of subscription (to include startup cost).

The device does not pinpoint an exact location where the participant is but gives a general location.

Remote monitoring reinforces 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.

This service is to provide support for conditions specifically related to IID/DD.

SERVICE LIMITS

- Remote monitoring device shall meet applicable standards of manufacture and design.
- Equipment & Supplies and Remote Monitoring will be limited to $5,000 per participant per waiver year with a maximum of $25,000 per waiver period, unless an exception is approved by the DHHS/DD to prevent imminent institutionalization. The authorization database tracks the amount authorized and utilized to prevent over expenditure. A "waiver period" is year 1 through year 5 of the current approved waiver.
- Experimental or prohibited treatments are excluded. These include treatments not generally accepted by the medical community as effective and proven, not recognized by professional medical organizations as conforming to accepted medical practice, not approved by FDA or other requisite government body, are in clinical trials or further study or are rarely used, novel, or unknown and lack authoritative evidence of safety and effectiveness.
- A written recommendation must be obtained by an appropriate professional and three separate trials of equipment, when appropriate, to ensure that the equipment will meet the needs of the participant and will be used, prior to consideration for approval. If an item being recommended by the appropriate professional is similar to an item that has been trialed, that recommendation must state how it is similar in order to be approved.

- Generic devices and items (e.g. apple watch, gizmo, apple air tag) are not allowed. Generic items are items relating to, or characteristics of, a whole group or class; having no particular distinctive quality or application; and lacking specificity.
    - Generic items are items that are not specialized for a disability or have not been modified/adapted to meet the needs of the disability. Generic items would typically be purchased for someone the same age/general population without a disability. Generic items are not indicative of a brand name.
- The subscription may be canceled at any time.
- This service cannot duplicate any other service in this waiver.
- The service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

FAMILY CARE OPTION (FCO)

Provider Managed: YES	**Self-directed:** NO
Service unit: daily rate	**Provider type:** DD Licensed Provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Family Care Option service is care for a child in a family home setting that meets the minimum licensing requirements for foster home. This service may be provided on a part-time or full-time basis for an eligible child under the age of 21, who cannot remain in their natural family home on a full-time basis.

Family Care Option focuses on close communication and coordination with families and the school system during the transition period. Support is provided as physical or verbal assistance to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, and show preference.

Family Care Option service helps to develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes and avocation; and aid involvement in family routines and participation in community experiences and activities.

Family Care Option is voluntary placement by the natural family. The natural family retains all decision-making authority and all legal, education, medical, and financial responsibility. Family Care Option is available only if the child is receiving the proper parental care and education necessary for the child's physical, mental or emotional health as referenced in NDCC 27-20-02 (5); and is not considered boarding care according to the definition of the North Dakota Department of Public Instruction

Participants may receive Day Habilitation outside the facility as long as the outcomes are consistent with the habilitation described in the participants plan and the service originates from the licensed day program. Participants receiving services in Family Care Option must have an active IEP (Individual Education Plan).

Family Care Option service is to provide for conditions specifically related to IID/DD.

SERVICE LIMITS

- Family Care Option is not provided in group residential settings.
- Family Care Option cannot be authorized on the individual service plan with Adult Foster Care, Residential Habilitation or Independent Habilitation service.
- IHS, Homemaker, Respite, and EHHC cannot be provided in the Family Care Option setting but may be authorized in the natural family home when the participant is present, and the requirements are met.
- To avoid duplication service is not available to children under the custody of county social service.
- Family Care Option service will not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, Parenting Support, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Family Care Option service cannot duplicate any other service in the waiver.
- This service may be provided by a relative but cannot be provided by a person who is legally responsible for the participant or a legal guardian of the participant.

IN-HOME SUPPORTS (IHS)

Provider Managed: YES	**Self-directed:** YES
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** YES
EVV Required: YES	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

In-Home Support service provides support to meet the excess care needs related to the participant's disability. In-Home Supports (IHS) benefits the primary caregiver by providing relief care (respite) when the primary caregiver is not present or when the primary caregiver is present and needs a second pair of hands to assist the participant in activities of daily living and maintaining health and safety. The service plan team determines the appropriate tasks or activities that are provided by IHS staff and this is included in the participant's person-centered plan.

Location

The participants receiving In Home Supports (IHS) are supported in the home and community in which they live or in the home of the support staff, if the home is approved by the legal decision maker.

In-Home Supports service is to provide for conditions specifically related to IID/DD.

Acute Care Hospital

In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, In-Home Supports may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings

and home and community-based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law. (See Provider Manual for additional guidance)

SERVICE LIMITS

- In-Home Support service is limited to a total of 300 hours per month per participant regardless of the delivery method unless an exception is approved by the DD Section.
- In- Home Supports may not be provided by primary caregiver, legally responsible person, or legal guardian.
- IHS may not be provided to a group of participants or in a facility-based setting (i.e. day habilitation, daycare, school).
- IHS cannot be authorized or provided when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP or when the participant is receiving home schooling.
- An IHS participant can be authorized to receive both provider managed and self-directed at the same time but cannot be furnished or billed at the same time of day. The authorized amounts are not transferable between the different service delivery methods (i.e self-directed, provider managed).
- For families who have more than one participant in the household receiving this service, each participant's individual needs are evaluated by the Team to determine if the total number of hours and staff can be combined to still ensure each participant's health and safety.
- In-Home Support payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid.
- IHS cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation or Adult Foster Care.
- In-Home Support cannot be provided in a Family Care Option setting but may be authorized in the natural family home when the participant is present and the requirements are met.
- In-Home Support service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, Extended Home Health Care, Parenting Support, Behavioral Consultation, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, Respite, or Individual Employment.
- In-Home Support service cannot duplicate services provided under any other service in the waiver.
- This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

INFANT DEVELOPMENT (ID)

Provider Managed: YES	**Self-directed:** NO
Service unit: Pay points- Home Visit, Consultation, Evaluation\Assessment, Plan Development	**Provider type:** Licensed DD provider
Virtual Supports: YES	**Allowable in Acute Care Hospital Setting:** NO

EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Infant Development service is only available to infants/toddlers age birth through two years of age. This service is a home-based, family focused service that provides information, support and training to assist primary caregiver(s) in maximizing the child's development utilizing a parent-coaching model. Infant Development professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. The primary caregivers, infant development professionals, and DDPM serve as a team and determine services necessary to meet the child and caregiver needs, along with the frequency and duration of services.

- Home visit: Home visitors coach the primary caregiver(s) in how to address the identified needs for their child.
  - Home Visits must be scheduled at least once a month, but may be scheduled multiple times a week. The expectation is that home visits will last about an hour and take place in the child's natural environments.

- Consults: Consults allow the opportunity for other members of the Team to coach both the primary caregiver(s) and home visitor in the area of their specialty.
  - The team will determine the expertise needed and what areas of consult are required to meet the child and family's needs and outcomes.

- Evaluation/Assessment: An evaluation is completed to determine eligibility for Developmental Disabilities Program Management (DDPM), as well as for Infant Development services, when a child applies for services.
  - An assessment is completed annually, after a child is eligible for services, to determine progress made on the outcomes, as well as to offer information for updating the plan.
  - Evaluations and Assessments must be conducted by at least two qualified ID personnel of different disciplines (either contracted or employed) from the Core Evaluation/Assessment Team.

- An Individual Family Service Plan (IFSP) is developed to identify services and learning opportunities to support the family in meeting the needs of their child, enhance their child's development, and increase the child's and family's participation in everyday routines and activities within the home and community.

- Plan Development/Update: The plan directs supports and services, in relation to the prioritized concerns and outcomes of the primary caregiver(s) and rest of the team.
  - Initial meetings must take place within 45 days of referral
  - Plans must be developed annually
  - Periodic reviews must occur at least every 6 months, however, can be more frequent to address child and family needs/concerns

Virtual Supports

This 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. (See Virtual Support Policy for additional information)

Infant Development service is to provide for conditions specifically related to IID/DD.

SERVICE LIMITS

- Infant Development services children birth through 2 years of age as they are not eligible for special education services available for children eligible for Part B-619 of IDEA offered through the North Dakota Department of Public Instruction
- Infant Development does not provide direct therapies nor can it be provided at the same time as other waiver services.
- Home visits cannot be conducted over the phone.
- Nursing consultations can only be billed when needed to ensure the child's health and welfare while participating in another Early Intervention service.
- Infant Development service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Self-Directed Services, Family Care Option, Respite, or Extended Home Health Care.
- Infant Development service cannot duplicate any other service in the waiver.
- Infant Development cannot be authorized on the individual service plan with Behavioral Consultation, Residential Habilitation, Independent Habilitation, Parenting Support, Adult Foster Care, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.

PARENTING SUPPORT

Provider Managed: YES	**Self-directed:** NO
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative: NO**

SERVICE DESCRIPTION

Parenting Support services may assist participants who are, or will be, parents in developing appropriate parenting skills. Parenting Support is different from other family support programs as the participant is the parent rather than the child. Participants receive individualized training that focuses on the developmental needs, health and welfare needs of their child. Close coordination is maintained with informal supports and other formal supports.

Parenting Support service is to provide for conditions specifically related to IID/DD.

SERVICE LIMITS

- Support is available from the first trimester, until the eligible participant's child is 18 years of age.

- Parenting Support service cannot be authorized on the individual service plan with Residential Habilitation or Independent Habilitation.
- Parenting Support is limited to an average of four (4) hours of individualized child-focused direct training per week during a quarter.
- If the eligible participant (parent) does not have physical custody or visitation rights, they will not receive individualized child-focused training, but group training and support activities will be provided.
- Parenting Support shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Family Care Option, Extended Home Health Care, Adult Foster Care, Behavioral Consultation, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.
- Parenting Support service cannot duplicate any other service in the waiver.

COMMUNITY TRANSITION SERVICES

Provider Managed: YES	**Self-directed:** NO
Service unit: item	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** NO
EVV Required: NO	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** NO

SERVICE DESCRIPTION

Community Transition Services is a one-time cost for non-recurring set-up expenses for participants who are transitioning from an institution to a home and community-based setting where the participant wishes to reside. Allowable community transition services are those where the participant is directly responsible for their living expenses and includes:

- essential household furnishings and moving expense required to occupy and use within their home; including furniture, window coverings, food preparation items and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water, and security deposits.

Items purchased via this service are the property of the participant.

SERVICE LIMITS

- 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 utilized for qualifying expenses up to 180 consecutive days prior to admission to the waiver and 90 days after the date the participant became eligible for the waiver.
- One-time transition costs are limited up to $3000 per eligible participant per waiver period.
- Community Transition Services are subject to prior authorization and funds are furnished only to the extent that they are necessary as identified in the service plan. The state utilizes a transitional budget form that details an inventory of expenses deemed necessary to move from an institution and establish a home in the community. The

funds are only available if the individual is unable to meet such expenses or when the services are not able to be obtained from other sources.

- The participant must be reasonably expected to be eligible for and to enroll in the waiver.
- This service is limited to participants coming from a ND Medicaid Institutional setting who have resided there for a minimum of 60 consecutive days.
- This service cannot duplicate any other service in this waiver.
- This service is limited to participants who are moving into a setting with 6 or fewer people.

RESPITE

Provider Managed: YES	**Self-directed:** YES
Service unit: 15 minute	**Provider type:** Licensed DD provider
Virtual Supports: NO	**Allowable in Acute Care Hospital Setting:** YES
EVV Required: YES	**SIS/ICAP:** NO
Medical Acuity Tiers: NO	**Service may be provided by:** • **Legally Responsible person:** NO • **Legal Guardian:** NO • **Relative:** YES

SERVICE DESCRIPTION

Respite services are services provided to the participant that give temporary relief to the primary caregiver from daily stress, care demands and to prevent or delay unwanted out of home placement. Temporary means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

A primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.

The team determines the activities and amounts of respite during the person-centered planning process and are specified in the individual plan of service.

Location

Respite may be provided in or out of the participant's home. The participants receiving Respite may be supported in their home, home of the support staff, camp, or other community settings, if approved by the legal decision maker.

Acute Care Hospital

In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act, Respite may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient's functions. This service will not be authorized to

substitute services that the hospital is obligated to provide under Federal or State law. (See Provider Manual for additional guidance)

This service is to provide support for conditions specifically related to IID/DD.

SERVICE LIMITS

- Hours of support will be limited to a total of 600 hours per State Fiscal Year per participant.
- Respite may not be provided by primary caregiver, legally responsible person, or legal guardian.
- Respite shall not be used as day/childcare.
- Respite is not intended to be provided on a continuous, long-term basis as part of daily services that would enable the primary caregiver to go to work or to attend school nor for the purpose of providing extra help while the primary caregiver is present.
- Respite may not include the cost of registration fees or the cost of recreational activities (for example, camp)
- Other family members (such as siblings of the participant) may not receive more than general supervision from the provider while Respite care is being provided/billed for the waiver participant(s)
- Respite cannot be authorized or provided when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP or when the participant is receiving home schooling.
- Respite may not be provided to a group of participants, in a facility-based program (i.e., day habilitation, daycare, school), or in Residential Habilitation or Independent Habilitation settings.
- For families who have more than one participant in the household receiving this service, each participant's individual needs are evaluated by the team to determine if the total number of hours and staff can be combined to still ensure each participant's health and safety.
- Respite can be authorized to receive both provider-managed and self-directed at the same time. The authorized amounts are not transferable between the different service delivery methods (i.e., self-directed, provider managed).
- This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Infant Development, Medicaid State Plan Services, In-Home Supports, Self-Directed Services, Day Habilitation, Prevocational Services, Small Group Employment Supports, Individual Employment Support, Homemaker, or Extended Home Health Care.
- Respite cannot be provided to participants receiving Adult Foster Care, Residential Habilitation, or Independent Habilitation.
- Respite cannot be provided in a Family Care Option setting but may be authorized in the natural family home when the participant is present and the requirements above are met.
- To avoid duplication, this service is not available to participants under the custody of county social services.
- This service cannot duplicate any other service in this waiver.
- This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

MEDICAID STATE PLAN SERVICES

Medicaid was created in 1965 through Title XIX of the Social Security Act. People must meet eligibility requirements, which is determined by the human service zone. The program is administered by each state within broad federal regulations by the Centers for Medicare and Medicaid Services (CMS).

Medicaid provides:

- Health insurance coverage to children and adults in low-income households, low-income pregnant women, the elderly, and people with disabilities.

- Long Term Care assistance to people in institutions (including Nursing Facilities and ICF/IID) and community-based residences (including Home and Community Based waiver services and supports)

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

ICF/IID is a Medicaid state plan benefit that enables states to provide long-term comprehensive and individualized health care and habilitation services to individuals to promote their functional status and independence. ICF/IID's are licensed residential facilities of 4 or more people for individuals with Intellectual Disability.

The programming provided in this type of residence is for individuals with extensive needs. Direct care staff is on duty 24 hours per day. Each individual must receive a continuous active treatment program, which includes an aggressive and consistent program of education, health services, and related services directed toward acquisition of skills to function with as much self-determination and independence as possible. The day support component for individuals residing in an ICF/ID is included in the rate.

To access ICF/IID services through the Medicaid State Plan, an individual must meet all eligibility criterion for:

1) DD Program Management as set forth in North Dakota Administrative Code (NDAC) 75-04-06.

2) North Dakota Medicaid

3) ICF/IID Level of Care

Resources:

Title XIX Procedures for ND Providers
https://www.hhs.nd.gov/sites/www/files/documents/Developmental%20Disabilities/16.5.b.%20Title%20XIX%20Procedures%20for%20Providers.pdf

State Operations Manual (ICF/IID Regulations)

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

PERSONAL CARE SERVICES

Medicaid State Plan Personal Care (MSP PC)

Personal Care services are provided under the Medicaid (MA) State Plan. Under the MA state plan, Personal Care is available to more individuals, as the eligibility criteria under the state plan does not require the person meet the Nursing Facility or ICF/IID level of care required under the waivers, unless the person needs an enhanced level of personal care services (Level B and Level C).

DDPMs are responsible to provide case management activities associated with Personal Care through the state plan for individuals who are eligible for and receiving DD Program Management. This includes individuals who reside in Basic Care facilities.

Personal Care is self-directed and does not include internal program coordination. The DDPM provides all case management activities. The individual, guardian, and/or natural support system are responsible for all other coordination. The DDPM is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual in obtaining a qualified service provider (QSP), monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

In order to receive Personal Care under the Medicaid State Plan:

1.An individual must be eligible for Medicaid and

2. Meet the minimum eligibility requirements for the personal care services per the Personal Care Eligibility and Needs assessment for DD.

Services consisting of a range of assistance, provided to an individual with disabilities or conditions that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the forms of hands-on assistance or cueing so that the individual can perform a task without direct assistance. Tasks may include assistance with bathing, toileting, transferring, eating, dressing, mobility, meal preparation, laundry, medication assistance, shopping, money management, hair, nail, and teeth care, etc. Services provided must be essential to the health and welfare of the individual, rather than the individual's family.

TARGETED CASE MANAGEMENT (TCM) WITH PERSONAL CARE SERVCES

The focus or purpose of **Targeted Case Management (TCM)** is to identify what the person needs to remain in their home or community and be linked to those services and programs.

An assessment must be completed, and a Care Plan developed. The client's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System or the THERAP System/MSP-PC Functional Assessment.

Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The client must be informed of that fact by noting Case Management Service and cost on the Individual Care Plan. Clients must also check and sign acknowledgment that if they are on Medicaid, they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are subject to estate recovery including for Targeted Case Management.

ACTIVITIES OF TARGETED CASE MANAGEMENT

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities

4-Monitoring and Follow-up Activities

TARGETED CASE MANAGEMENT (TCM) ELIGIBILITY REQUIREMENTS:

The individual receiving TCM will need to meet the following criteria:

- Medicaid recipient.
- Not currently be covered under any other case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose
- Not a recipient of HCBS (1915c) waiver service.
- Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.
- Has "long-term care need." Document the required "long-term care need" on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.
- Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.
- The applicant or referred individual must agree to a home visit and provide information in order for the process to be completed.

GENERAL FUND SERVICES

General funds are state dollars designated by the ND legislature to provide services within the limits of legislative appropriation. In DD, general funds have been appropriated in limited circumstances only when a service does not qualify for federal Medicaid financial participation, or an individual does not qualify for the ICF/IID level of care to access Medicaid financial participation through the waiver.

SECTION 11 FUNDS

Section 11 funding is appropriated by the ND Legislature to provide state general dollars for residential supports or employment support for individuals aged 21 and older who meet the following criteria:

1. Individuals eligible for DD Program Management; and are Medicaid eligible, but do not meet the ICF/IID level of care criteria for the ND IID/DD Home and Community based waiver.

2. Individuals who are eligible for DD Program Management needing residential or job supports but are not Medicaid eligible because they do not meet the criteria for disabled according to Social Security disability determination standards.

CORPORATE GUARDIANSHIP

The legislature has appropriated state general funds dollars to finance a contract to provide corporate guardianship services to individuals aged 18 and older who need a legal guardian but do not have family or friends to serve in this capacity. The contract is limited to a certain number of guardianship slots. If a slot is not available, the individual is placed on a waiting list.

The individual must be eligible for DD Program Management service and the DDPM is who can petition the courts for corporate guardianship. The corporate guardianship program is contracted with Catholic Charities of North Dakota.

https://www.catholiccharitiesnd.org/guardianship-division-intellectual-disabilities

SECTION XIV – RATE GUIDELINES AND MATRIX - APPENDIX B

2025/2026 Salary Reimbursement Levels

Direct Care Staffing effective 7/1/2025 through 6/30/2026

Provider Managed In-Home Support, Respite & Parenting Supports

$8.46/hour Administration

$4.26/hour Program Coordination

	Salary Allowance	Salary & Fringe
	$21.20	$28.20
Annual	$44,096	$58,656

$10.23 15 min rate

Self Directed In-Home Supports & Respite

	Salary Allowance	Salary & Fringe
	$21.20	$28.20
Annual	$44,096	$58,656

Family Care Option

$11.14/day Administration

$5.04/day Program Coordination

Infant Development Fee-For-Service Rates for 2025-2026

Activity	
Evaluation	$560.26
Individual Family Service Plan	$542.60
Home Visits	$163.61
Consultation	$340.15

DD Provider Extended Home Health Care Rate for 2025-2026

$11.10 15 min rate

State of North Dakota
Rate Matrix
Fully Loaded Hour Value: "The Brick"

Effective July 1, 2025

2% Vacancy

Column Reference :		D	E	F	G	H	I	J	K	L	M	N			
Component Driven				D X E	D + F	Relief	G x H	G + I		D x K	J + L	General &	With	F	At
Service		Wage	ERE	ERE $	Sub	Staff	Relief $	Sub	P S	PS $	Sub	Admin	V Factor	%	Funded %
Residential Services															
ICF-ID	d	$20.42	35.1%	$7.17	$27.59	14.0%	$3.86	$31.45	87.2%	$17.81	$49.26	$54.73	$55.85	89.7%	$50.09
ICF-ID Medically Involved	d	$20.42	35.1%	$7.17	$27.59	14.0%	$3.86	$31.45	166.0%	$33.90	$65.35	$72.61	$74.09	89.7%	$66.46
ICF-ID Medically Intensive	d	$20.42	35.1%	$7.17	$27.59	14.0%	$3.86	$31.45	244.0%	$49.82	$81.27	$90.30	$92.14	89.7%	$82.65
Residential Habilitation	d	$20.50	35.1%	$7.20	$27.70	14.0%	$3.88	$31.58	39.6%	$8.12	$39.70	$44.11	$45.01	91.6%	$41.23
*Res Medical Acuity - Level 1	d	$20.50	35.1%	$7.20	$27.70	14.0%	$3.88	$31.58	42.7%	$8.75	$40.33	$44.81	$45.72	91.6%	$41.88
*Res Medical Acuity - Level 2	d	$20.50	35.1%	$7.20	$27.70	14.0%	$3.88	$31.58	64.7%	$13.26	$44.84	$49.82	$50.84	91.6%	$46.57
*Res Medical Acuity - Level 3	d	$20.50	35.1%	$7.20	$27.70	14.0%	$3.88	$31.58	92.1%	$18.88	$50.46	$56.06	$57.20	91.6%	$52.40
Independent Habilitation	h	$20.53	35.1%	$7.21	$27.74	14.0%	$3.88	$31.62	36.1%	$7.41	$39.03	$43.36	$43.36	100.0%	$43.36
Vocational/Day Services															
Day Habilitation	h	$20.48	35.1%	$7.19	$27.67	14.0%	$3.87	$31.54	56.7%	$11.61	$43.15	$47.94	$47.94	100.0%	$47.94
Prevocational Services	h	$20.48	35.1%	$7.19	$27.67	14.0%	$3.87	$31.54	56.7%	$11.61	$43.15	$47.94	$47.94	100.0%	$47.94
Small Group Employment Supports	h	$20.48	35.1%	$7.19	$27.67	14.0%	$3.87	$31.54	56.7%	$11.61	$43.15	$47.94	$47.94	100.0%	$47.94
*Day/Voc Medical Acuity - Level 1	h	$20.48	35.1%	$7.19	$27.67	14.0%	$3.87	$31.54	63.6%	$13.03	$44.57	$49.52	$49.52	100.0%	$49.52
*Day/Voc Medical Acuity - Level 2	h	$20.48	35.1%	$7.19	$27.67	14.0%	$3.87	$31.54	69.4%	$14.21	$45.75	$50.83	$50.83	100.0%	$50.83
*Day/Voc Medical Acuity - Level 3	h	$20.48	35.1%	$7.19	$27.67	14.0%	$3.87	$31.54	77.8%	$15.93	$47.47	$52.74	$52.74	100.0%	$52.74
Individual Employment Supports	h	$26.90	35.1%	$9.44	$36.34	14.0%	$5.09	$41.43	23.1%	$6.21	$47.64	$52.94	$52.94	100.0%	$52.94

* Medical Acuity Tiers may be applied to individuals with a SIS Medical Score of 15 or higher and is available to a qualifying provider in Residential Habilitation, Day Habilitation, Prevocational Services, and Small Group Employment Supports only.

5/19/2025 - All rates have been adjusted to include a 2% legislatively approved inflationary adjustment.

Understanding the components of the rate matrix:

- *Direct service staff wage (column D - wage) – staff who are performing tasks in the furtherance of the objectives of the service.*

- *Employment related expenses (column E - ERE) – all the benefits received by employees of the agency. This includes discretionary and non-discretionary benefits.*

- *Relief staff (column H) – a provision included in the rate to add 14% to provide funds to hire staff as direct service staff when other staff members are not available to work (i.e., vacation, sick leave).*

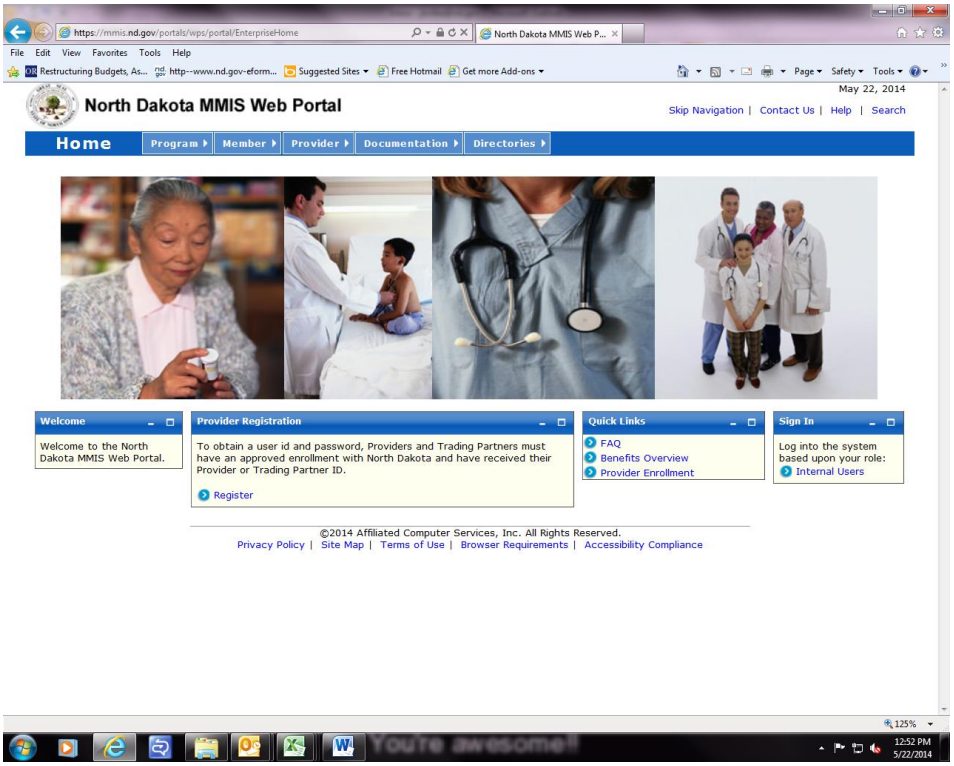
- *Program related expenditures (column K - PS) – expenditures that support the objectives and the provision of the service but cannot be tied to a particular person receiving services. These are considered "indirect" expenditures (i.e., supervision of direct service staff, supplies related to the service, consultative services to general staff, facility costs, training).*

- *General and administrative expenditures (column N – general & admin) – expenditures that are related to the cost of being in business. These have nothing to do with the program, service or the product offered. They tend to include administrative salaries, insurance, travel, office expenses, lease or rental costs for office space, etc.*

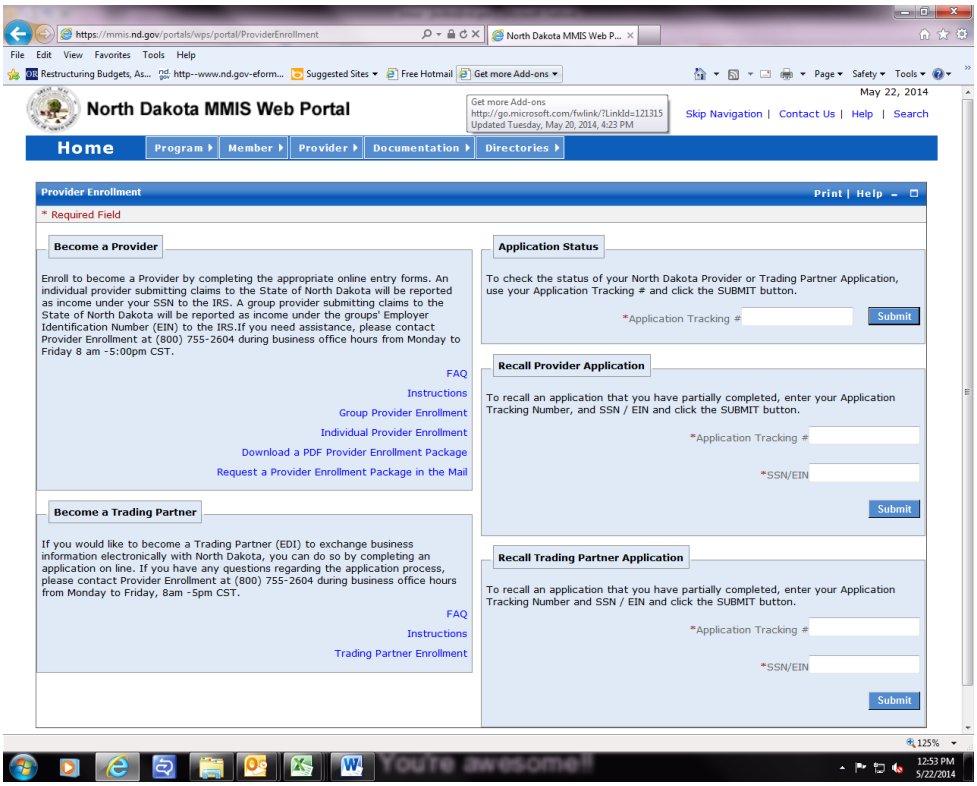
SECTION XV – HE MMIS ENROLLMENT AND CLAIM SUBMISSION (VIA THERAP OR MMIS PORTAL) - APPENDIX C

How to enroll as a DD provider in Enterprise:

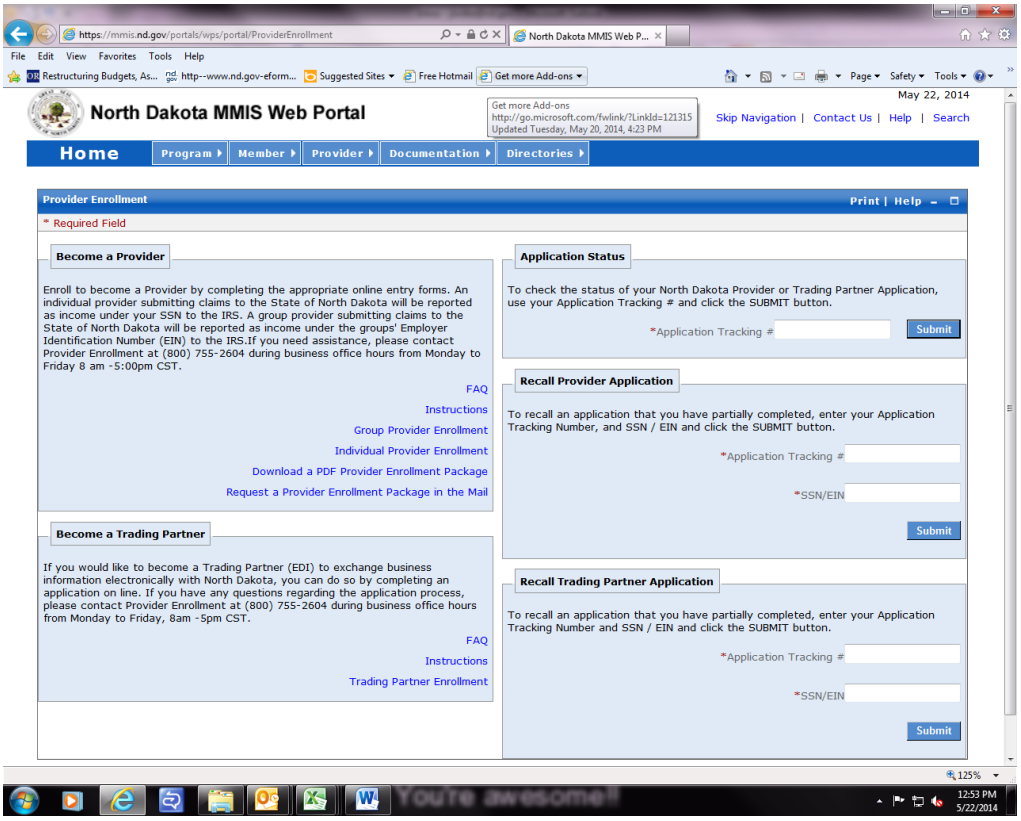
1. Become licensed by the DHHS-DD Section.
2. Complete a SFN 615 & DD Provider Addendum with DHHS (contact the DD Section).
3. Go to https://mmis.nd.gov/portals/wps/portal/EnterpriseHome to complete provider enrollment on the enterprise system to receive payment for services rendered
4. Select “Provider Enrollment” under Quick Links



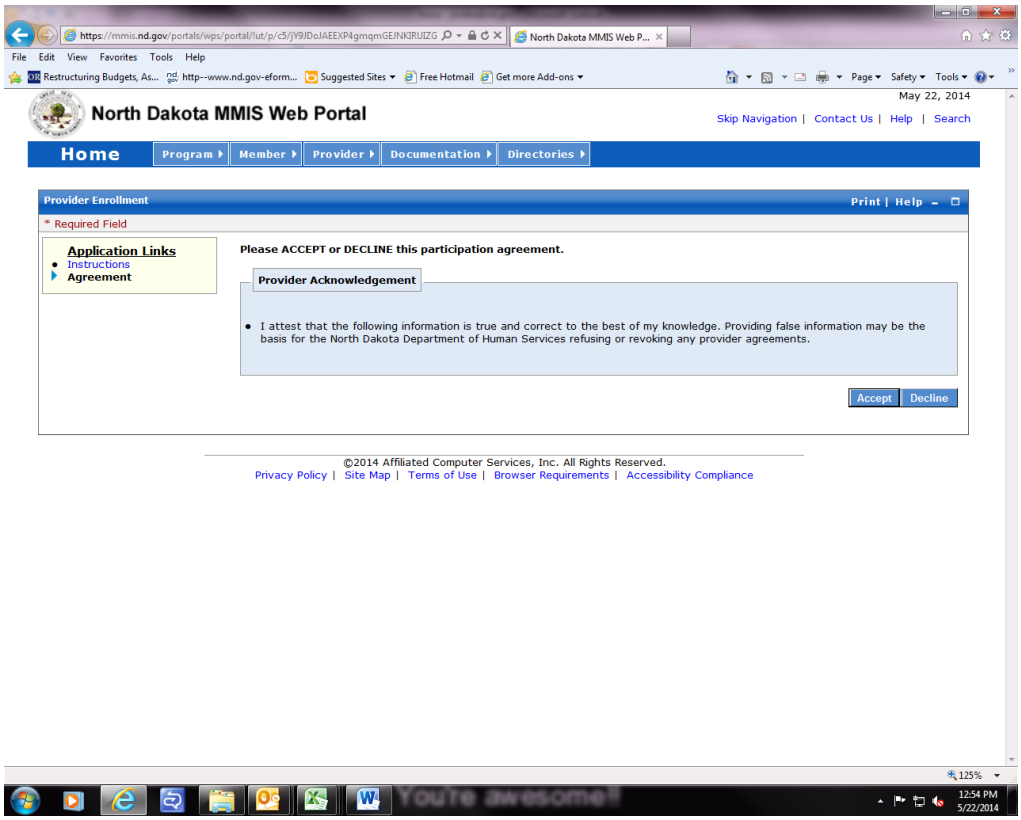
5. Select “Group Provider Enrollment” under Become a Provider section



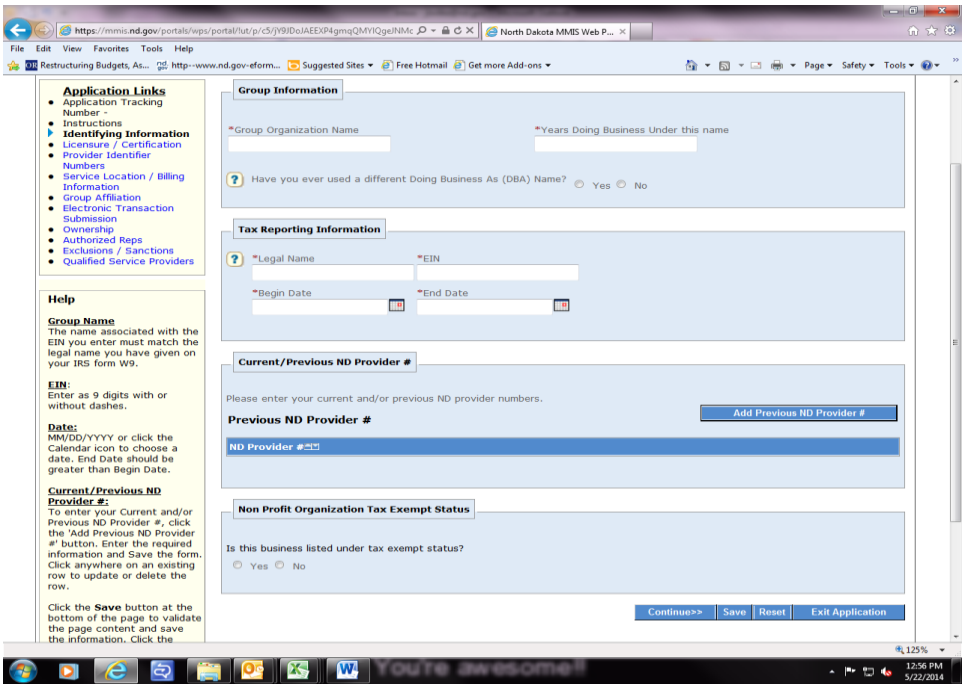
6. Select “Continue”



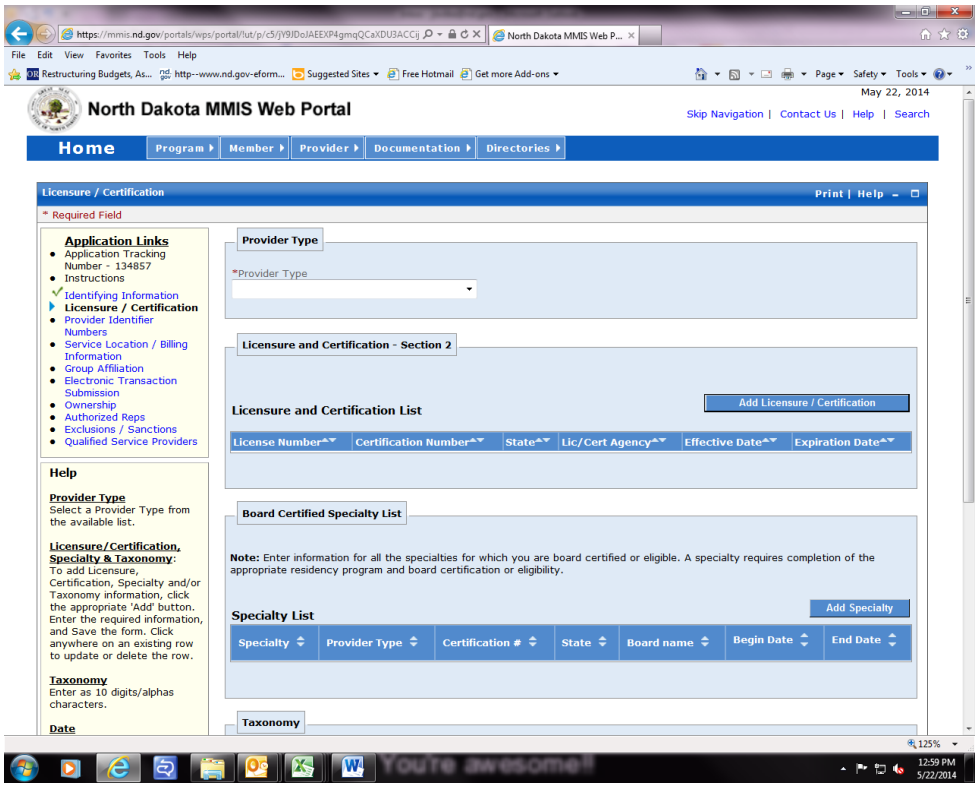
7. Select “Accept”



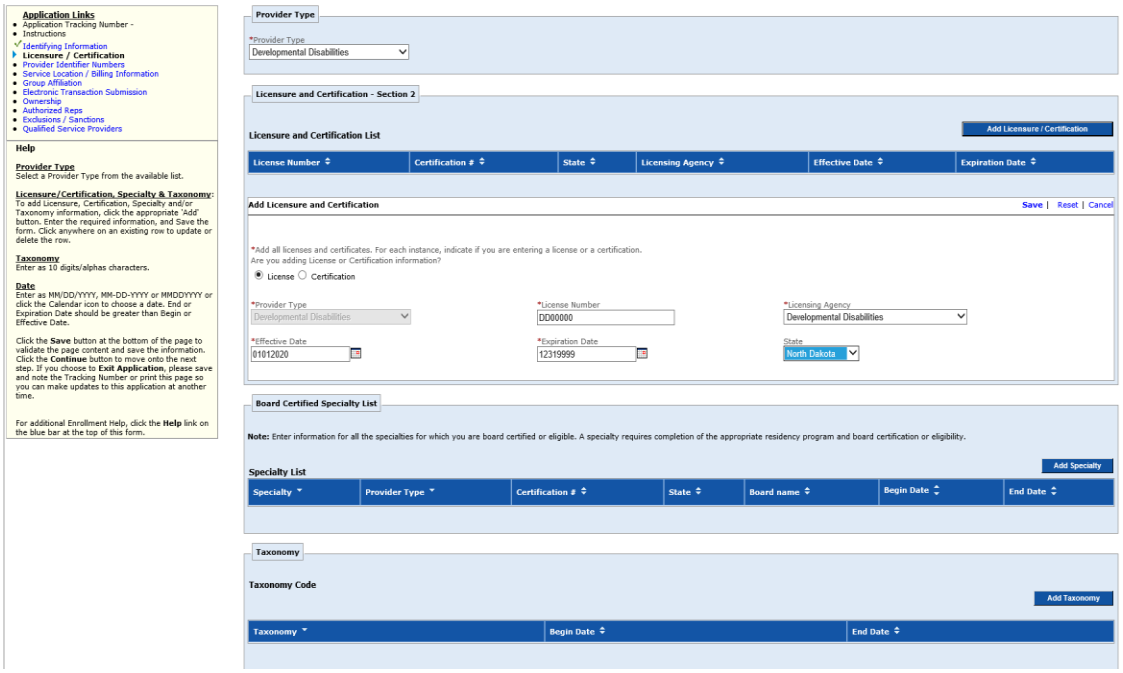
8. Complete identifying information section of application. After completing select “Save”, then “Continue”. Do NOT use any commas, periods, hyphens, etc. in this screen. End date use “12/31/9999”



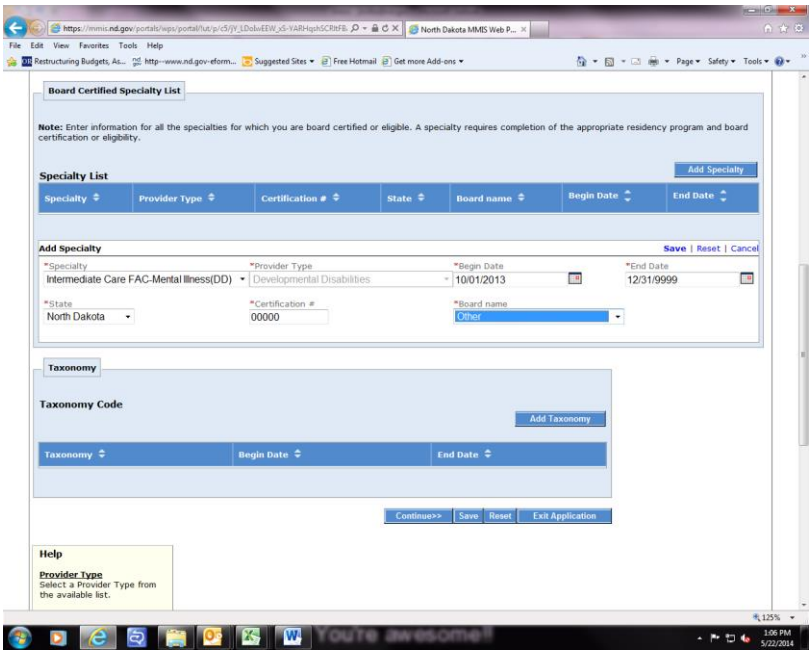
9. Complete “Licensure/Certification” section of application.
    a. Provider Type is 039-Developmental Disabilities.
    b. Select “Add Licensure/Certification”



    i. Select “License”
    ii. License number is “DD00000”
    iii. Licensing Agency is “Developmental Disabilities
    iv. Effective Date is the date the license issued by DD is effective
    v. Expiration date coincides with your license issued by the DD Section
    vi. State is North Dakota
    vii. Select “Save” in the small box



i. Select “Add Specialty”
ii. Choose correct Specialty from drop down box.
    a. List of type 039 specialties can be found here: https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf
iii. Begin Date is the date the agency was approved to provide the selected specialty.
iv. End date is 12/31/9999
v. State is North Dakota
vi. Certification # is 00000
vii. Board Name is “Other”
viii. Select “Save” within box.



ix. Select “Add Taxonomy”

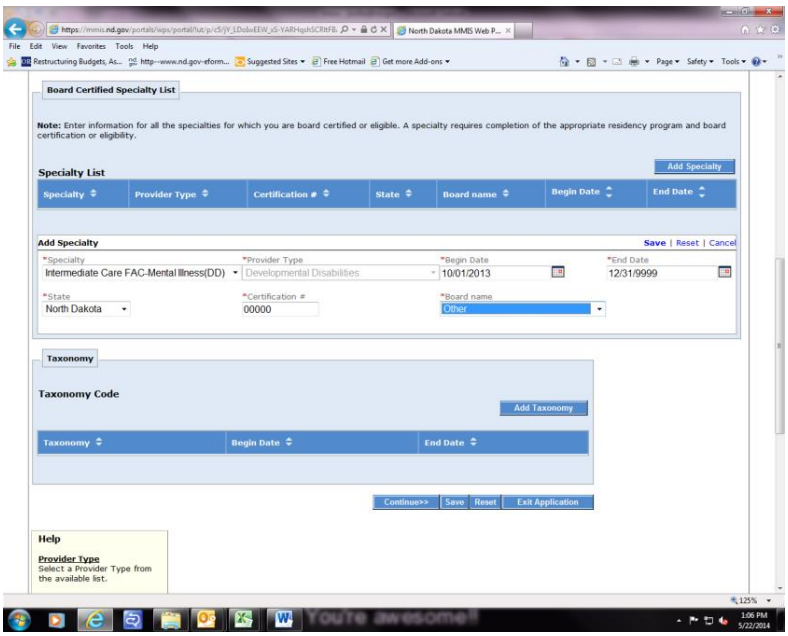
a. Add Taxonomy number.

i. List of taxonomies for provider type 039 can be found here: https://www.nd.gov/dhs/info/mmis/docs/mmis-individual-provider-code-taxonomy.pdf

b. Begin Date is the date the license began

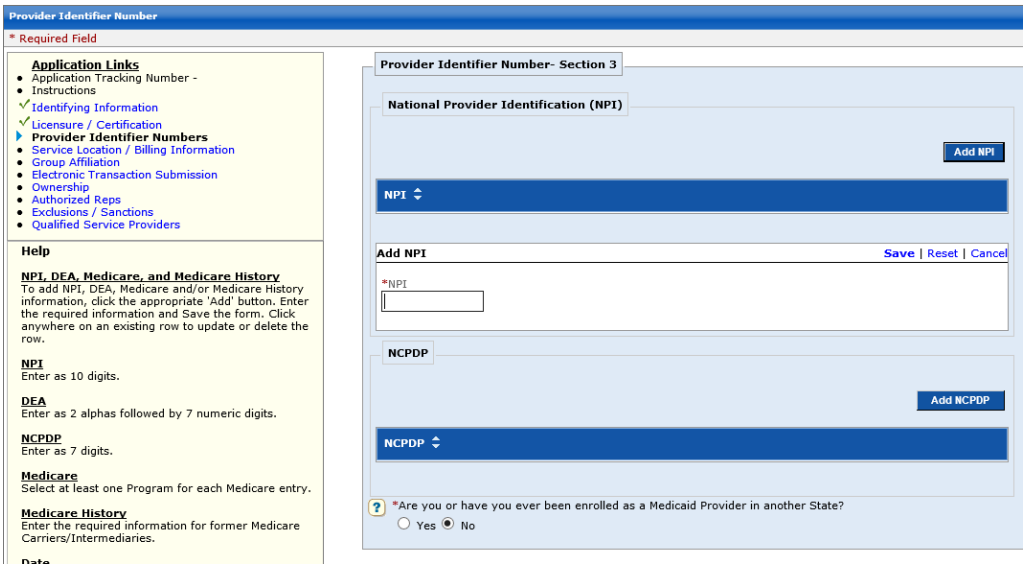
c. End Date is 12/31/9999

d. Select “Save” within box.



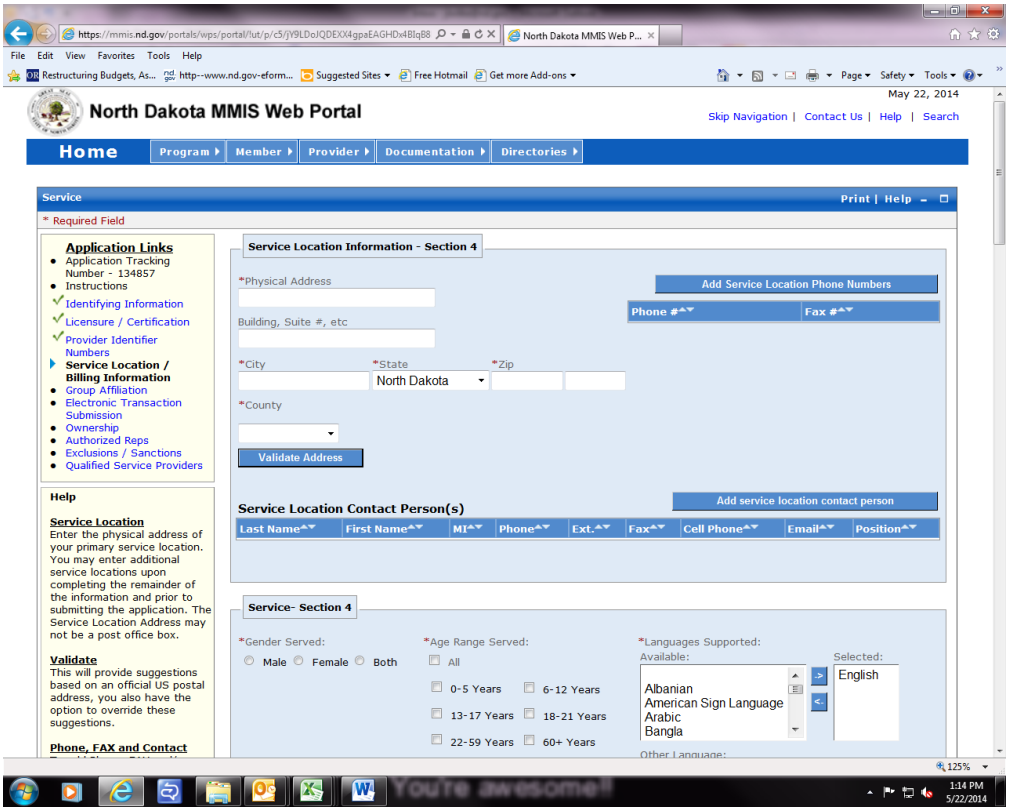
x. Select “Save” overall, then select “Continue”.

10. Complete “Provider Identifier Numbers” page of application.
    a. Select “Add NPI” and enter the number then “Save” with in the box.



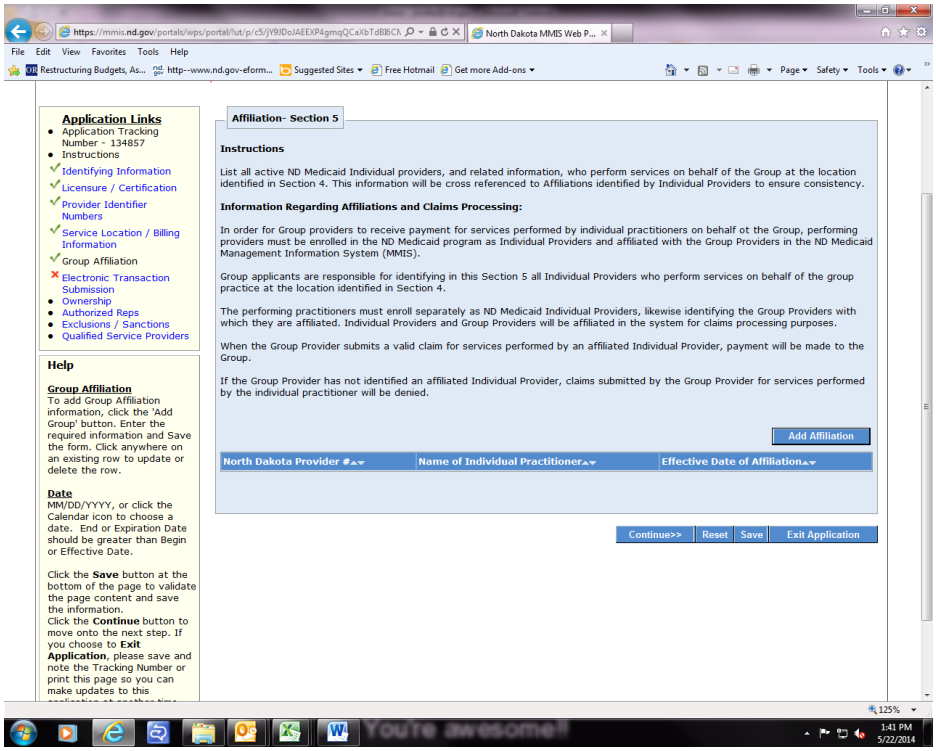
    b. Select “Save” overall, then select “Continue”

11. Complete “Service Location/Billing Information” section of the application.

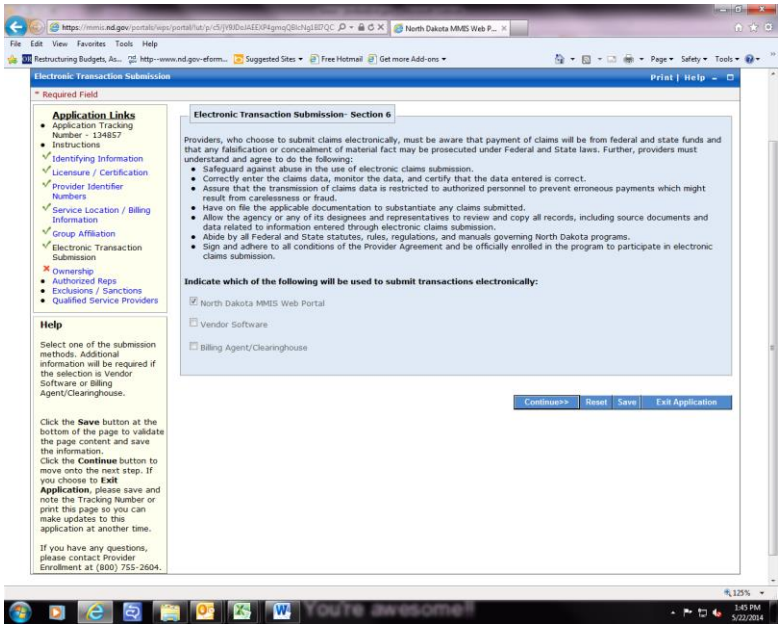


    a. Answer with the best possible answer.
    b. This is where you will enter your banking information if you wish to receive Electronic Funds Transfer (EFT) payments versus a paper check.
    c. Select “Save” overall, then “Continue”.

12. Select “Continue” on the “Group Affiliation” section of the application. It is not something DD or ICF providers need to fill out.

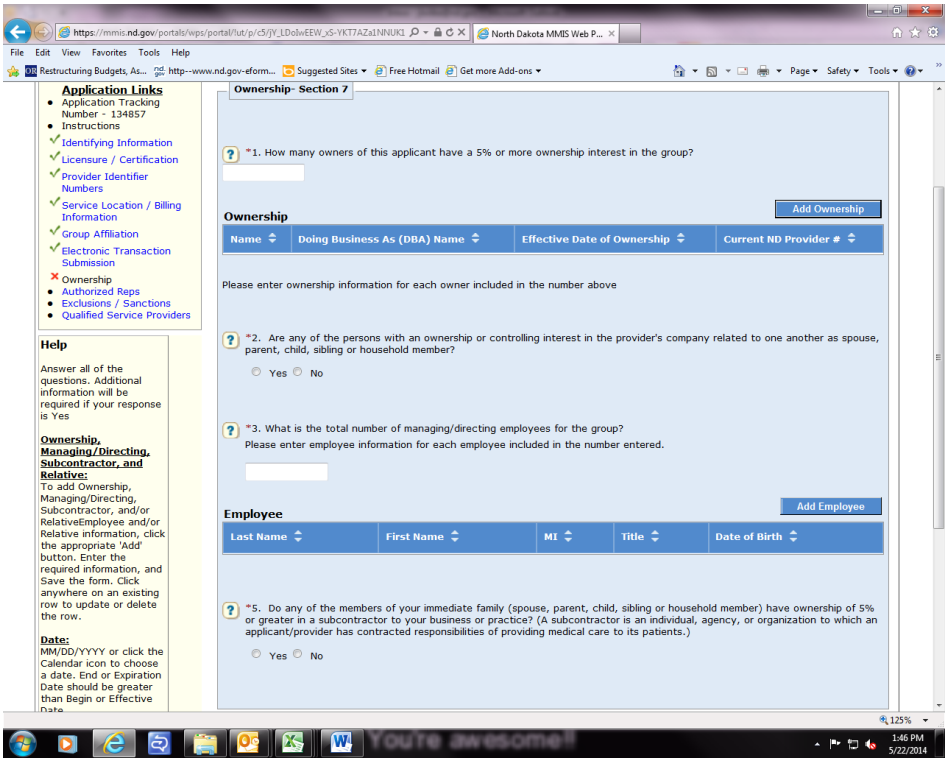


13. Complete the “Electronic Transaction Submission” section of the application.
    a. Select “North Dakota MMIS Web Portal” if you submit your own claims through the MMIS web portal.
    b. Select “Vendor Software” if you use Noridian or have your own software you use to submit claims.
    c. Select “Billing Agent/Clearinghouse” if you use any company besides Noridian to submit claims. i.e. Therap
        i. If this option is selected – complete a SFN 583: https://www.nd.gov/eforms/Doc/sfn00583.pdf
        ii. Fill out information as best to your knowledge. This information will be used to create a Trading Partner.



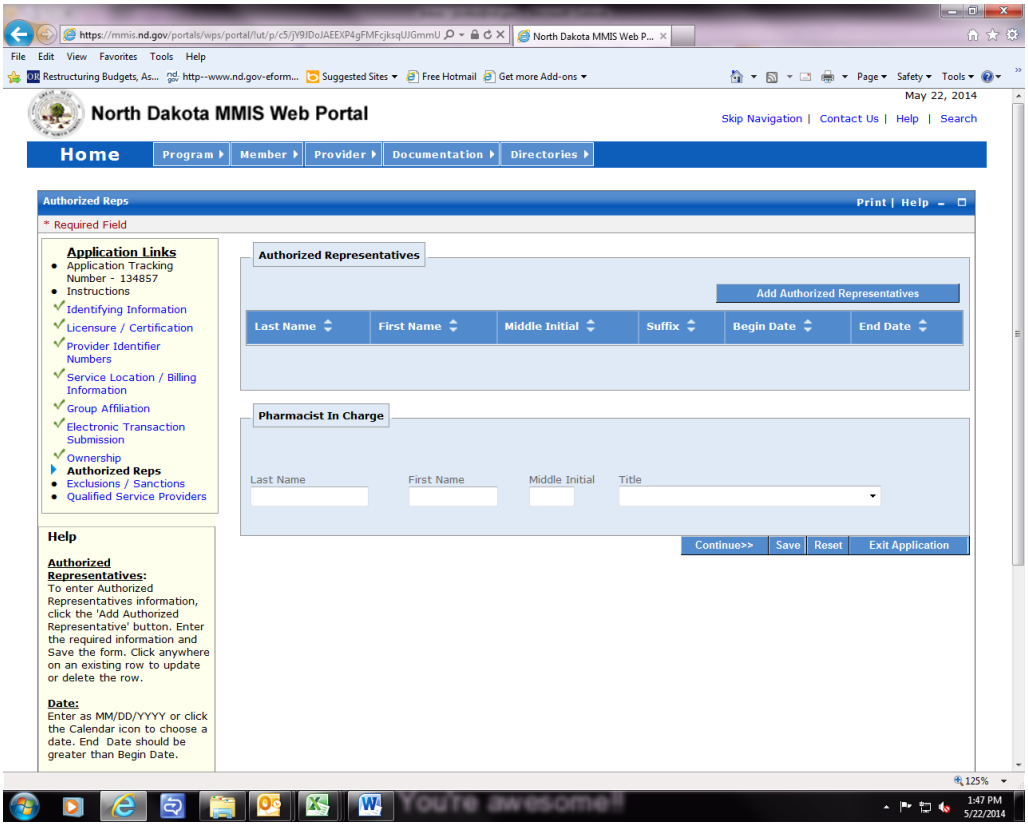
d. Select “Save” overall, then “Continue”

14. Complete “Ownership” section of application if it is applicable to your agency.
    a. Fill in applicable information. Also, complete SFN 1168 and send to the DD Licensing Administrator with the DD Section.



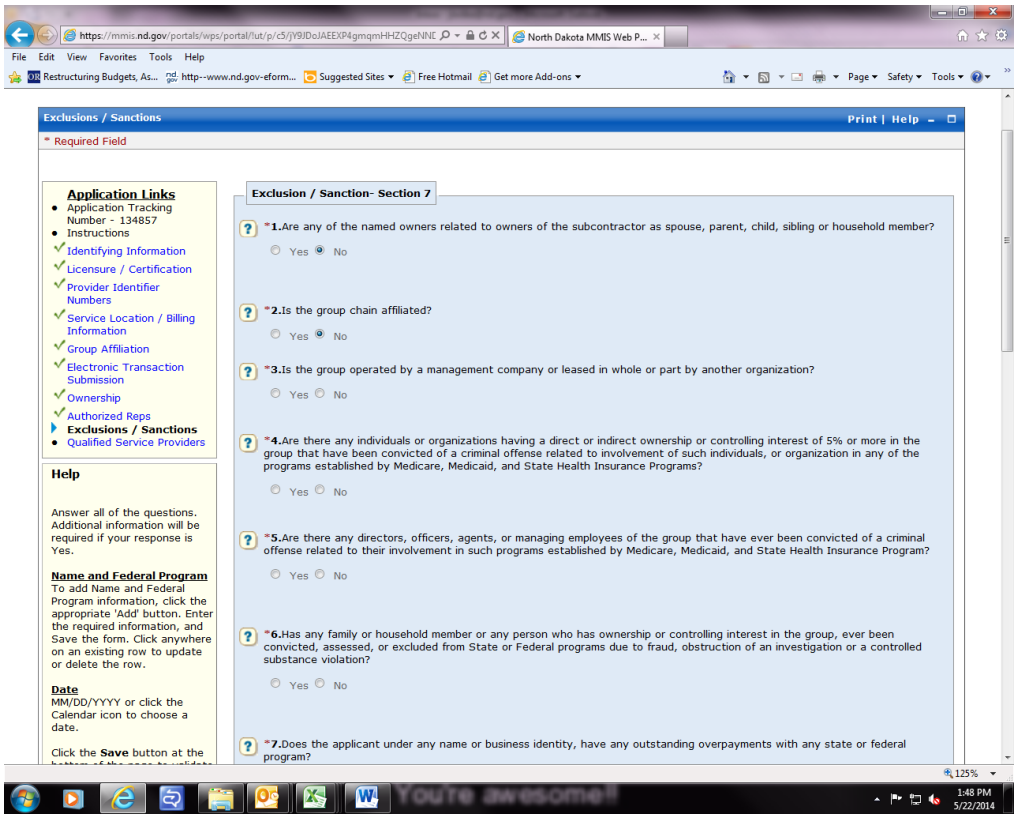
a. Select “Save” overall, then “Continue”

15. Complete “Authorized Reps” section of the application as it relates to your agency.
    a. Fill in applicable information.



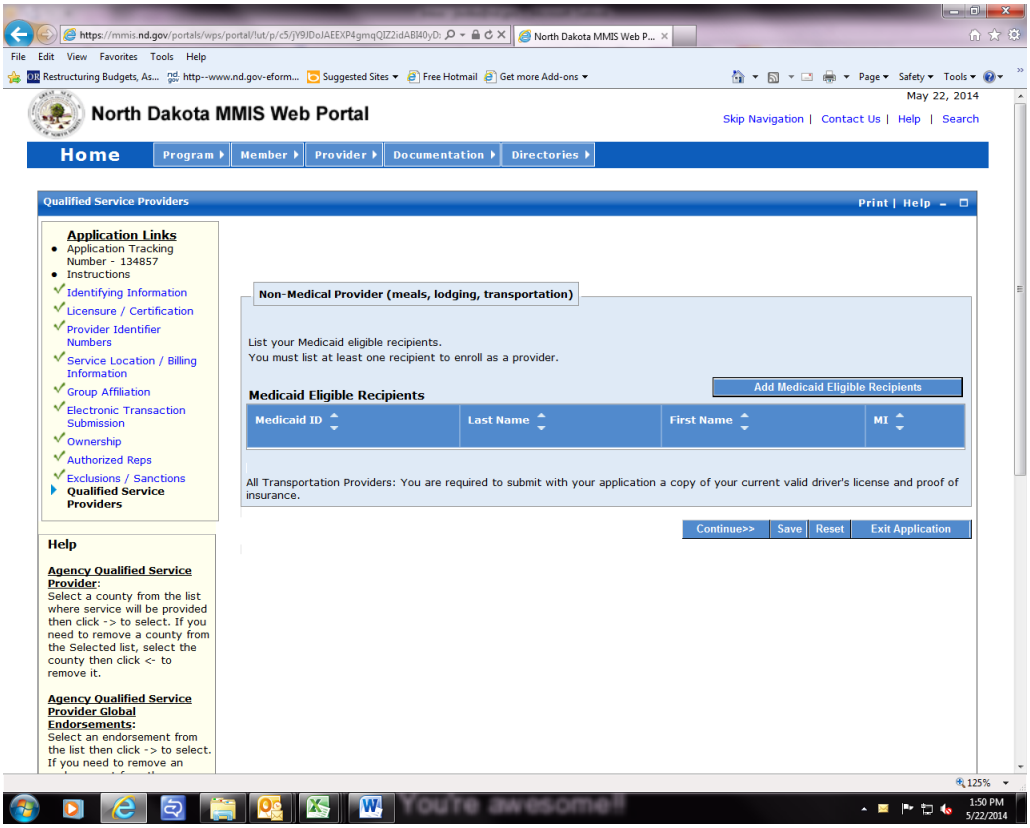
    b. Select “Save” overall, then “Continue”

16. Complete “Exclusions/Sanctions” section of the application as it relates to your agency.

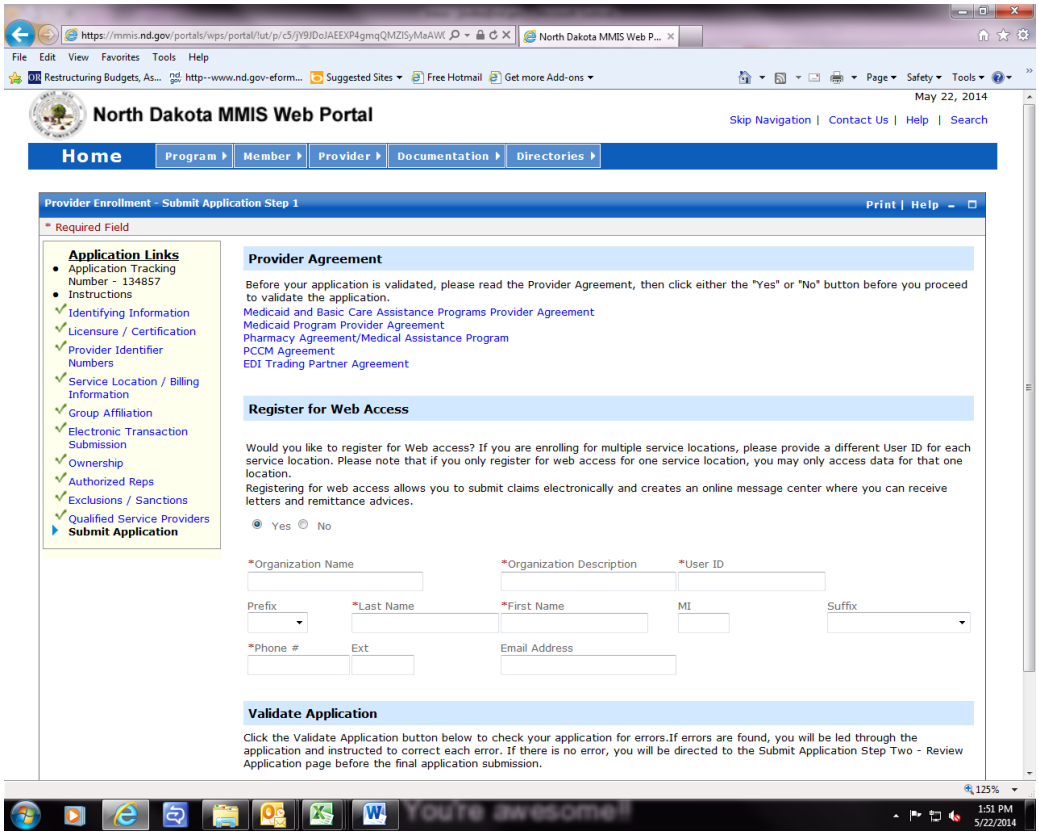


a. Select “Save” overall, then “Continue”.

17. Select “Continue” on the “Qualified Service Providers” section of the application. It is not something DD or ICF providers need to fill out.



18. Complete “Submit Application” section of the application.
    a. If you’d like to access your remittance advices, submit claims, etc. through the internet complete the “Register for Web Access” section. If you would not like this option, choose “No”.

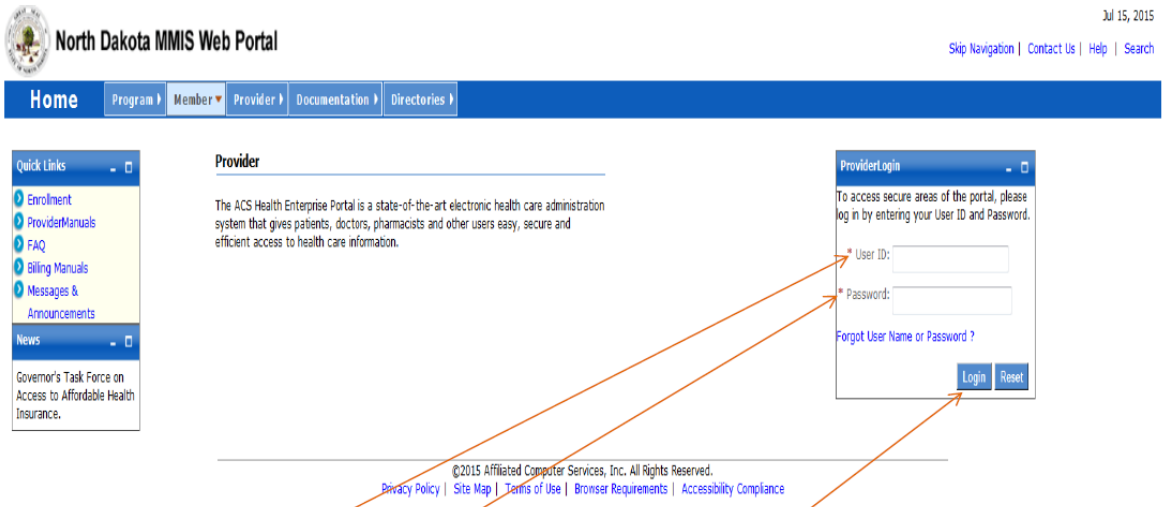


    b. Select “Save” overall, then “Validate Application”.
    c. After reading, select “I have read and agree to all terms and conditions stated in the Provider Agreement”.
    d. Enter “Requested Claim Submission Effective Date”
    e. Select “Confirm Submit”
    f. Your application is now submitted, print a copy for your records by selecting “Print Application”
    g. Select “Exit application”

MMIS Organizational Administrator Role, Waiver Service Billing Instructions for Completing Claim Form via MMIS Web Portal & Member look up

- Login in by selecting "**Providers**" in the sign in box on the right hand side of the webpage.
- https://mmis.nd.gov/portals/wps/portal/EnterpriseHome

DD Provider - Login

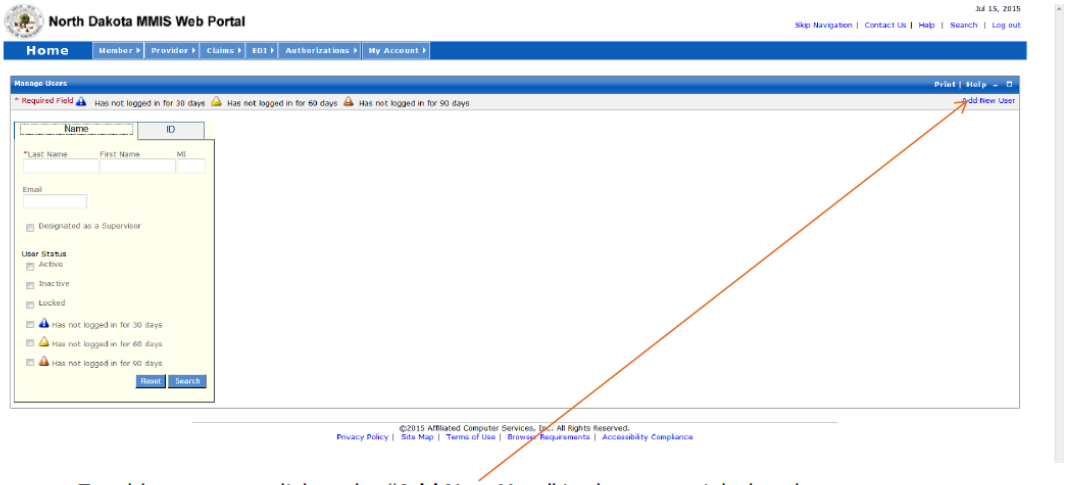


- Enter **User ID** and **Password** combination and select "**Login**".

DD Provider – Organization Administrator

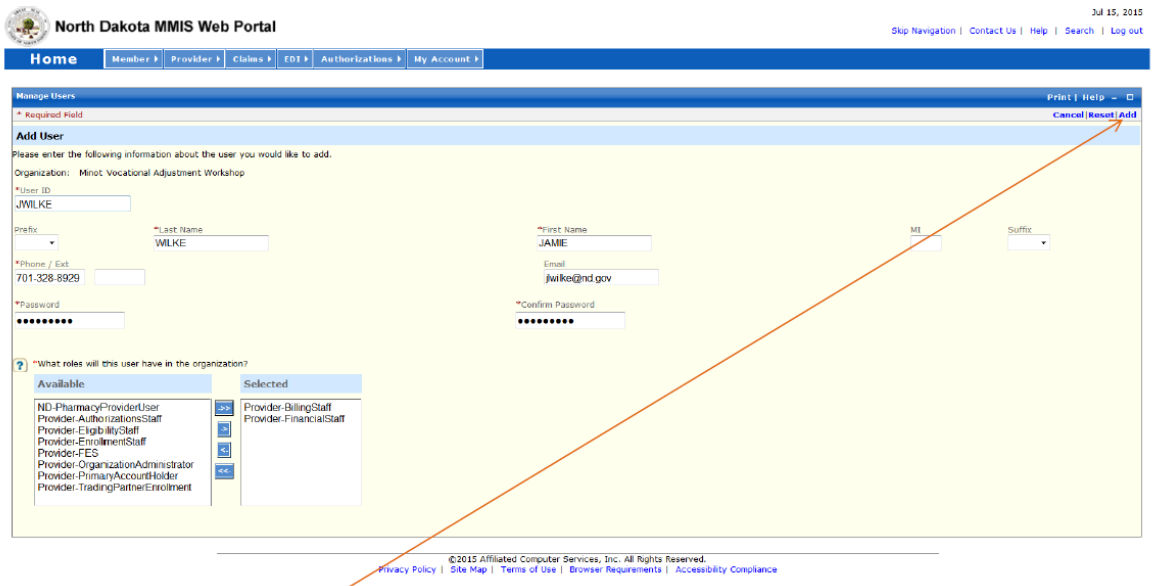
- As an organization administrator you can add, change, or delete additional accounts by selecting **My Account**, then **Manage Users**.

DD Provider – Organization Administrator



- To add a new user click onthe "**Add New User**" in the upper right hand corner.
- To change or delete a user you can either search by name or user ID in the tabs "**Name**" or "**ID**".

DD Provider – Organization Administrator

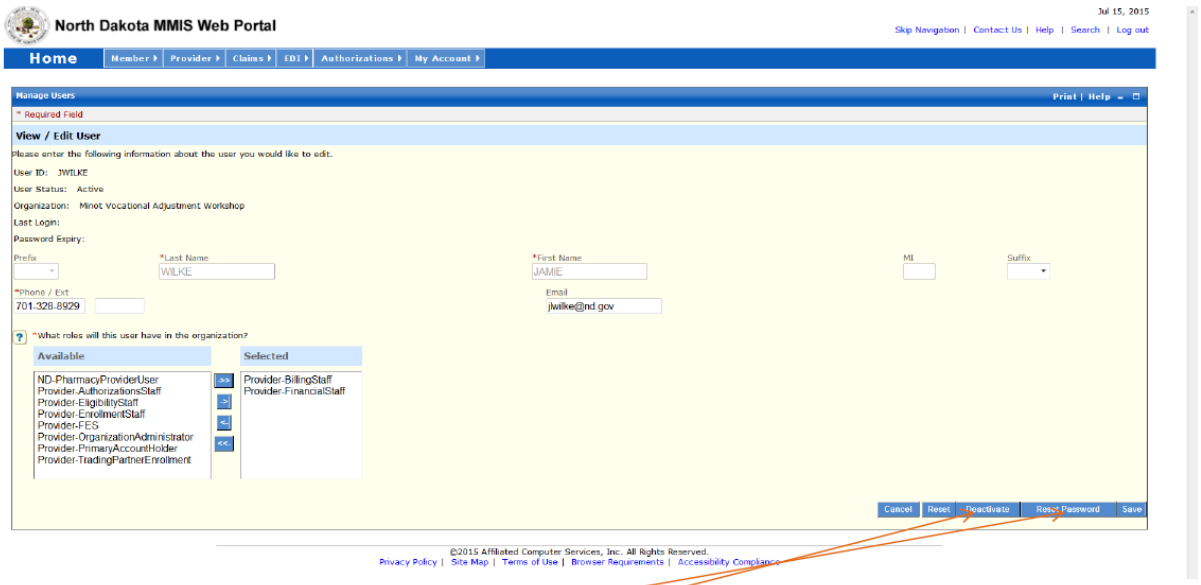


- All fields with red asterisk must be filled in.
- Different roles can be assigned. It is recommended to have two or three organization administrators roles.
- After you click on "**Add**" in the upper right hand corner there should be a response of "The user is created successfully"
- Note: User ID must have the first letter of the first name and the last name. It must be a minimum of 6 characters and a maximum of 20 characters.

DD Provider – Organization Administrator

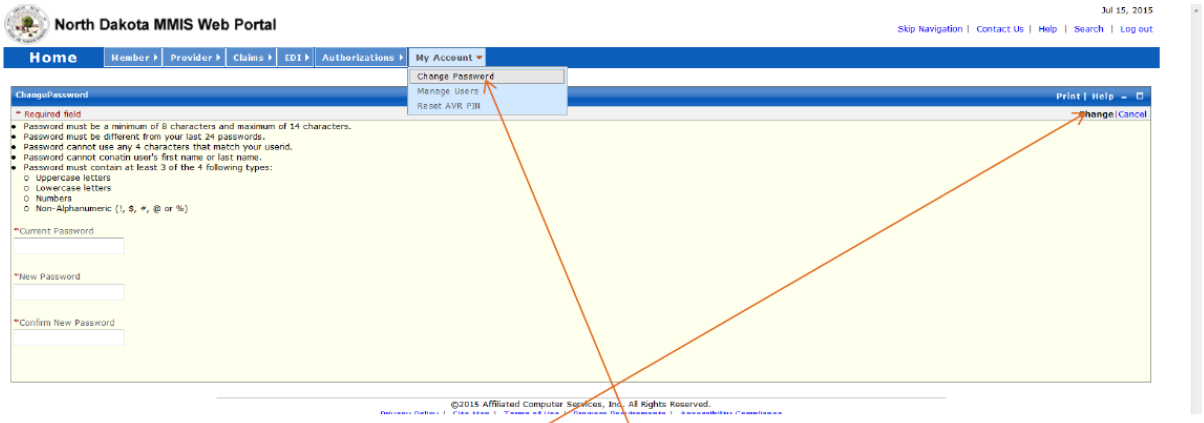
- You can view/edit users by searching by name – i.e. Wilke, Jamie – select "**Name**" tab in the yellow box
- You can view/edit users by searching by user ID – i.e. jwilke – select the "**ID**" tab in the yellow box
- Either option is also how to reset passwords or deactivate user.

DD Provider – Organization Administrator



- To reset password click on the "**Reset Password**" button, then click on the "**Save**" button.
- To deactivate account click on the "**Deactivate**" button , then click on the "**Save**" button.

DD Provider – User Password Change



- To change your own password select "**My Account**", "**Change Password**". Fill out the three boxes as instructed. Then click on "**Change**".

DD Provider – Service Authorizations

- There is no change to the service authorization process for DD providers
  - Authorizations will continue to be inputted into Therap by DDPMs.

Step 1: Obtain National Provider Identifier (NPI) number.

Q. What is an NPI Number?

A. 10-digit numeric identifier that will not change, even if your name, address, taxonomy, or other identifiers change. It will be required to bill DD services electronically in MMIS as of January 1, 2021.

Before applying for an NPI, you will need to know the taxonomy code you should use and that you are applying for a Type 2 NPI: Organizational Providers (Group).

- **NPI Type 2: Organizational Providers (Group)**
- Resource: NPI What you Need to know
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPI-What-You-Need-To-Know.pdf
- Frequently Asked Questions: https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html

Taxonomy Codes

01

A taxonomy code describes the Individual Provider **or** Organization/ Group type, classification, and the area of specialization.

02

In the NPI application you will be asked to identify a taxonomy code.

03

DD Taxonomy Codes:

Provider Type	Provider Specialty Code	Taxonomy Code
39-DD	620-Day Habilitation	251S00000X
39-DD	379-Family Support Services (DD)	251S00000X
39-DD	555-Individual Employment Support	251S00000X
39-DD	621-Independent Habilitation	251S00000X
39-DD	372-Infant Development (DD)	252Y00000X
39-DD	369-Intermedicate Care Facilities for Individuals with Intellectual Disabilities -(ICF/IID) (DD)	315P00000X
39-DD	557-Prevocational Services	251S00000X
39-DD	622-Residential Habilitation	251S00000X
39-DD	501-Self-Directed Supports	251S00000X
39-DD	556-Small Group Employment Support	251S00000X

DD Provider- Service Codes (Professional Claims)

Billing codes for developmental disability services			
	DD Billing Codes in MMIS		
Service type	**HCPC code**	**Modifier**	**Billing unit**
Day Habilitation	T2021		15 min
Prevocational Services	T2047		15 min
Individual Employment Supports	T2019		15 min
Small Group Employment Supports	T2019	HQ	15 min
Homemaker	S5130		15 min
Residential Habilitation	T2016		daily
Residential Habilitation- Retainer	T2016	U5	daily
Independent Habilitation	T2017		15 min
Extended Home Health Care	G0300		15 min
Adult Family Foster Care	S5140		daily
Adult Family Foster Care-Respite Care	S5150		15 min
Behavioral Consultation	S5131		per diem
Environmental Modifications	S5165		each
Equipment & Supplies	T2028		each
Family Care Option I	T2033		daily
In-Home Supports			
In Home Supports Provider	S5125		15 min
In Home Supports Provider- secondary staff	S5125	XP	15 min
In Home Supports Self-Directed	S5126		per diem
Respite			
Respite Provider	S5150		15 min
Respite Provider- secondary staff	S5150	XP	15 min
Respite Self-Directed	S5151		Per diem
Infant Development			
Evaluations /Assessments	T1023		each
Individual Family Support Program	T2024		each
Home Visits	S5111		each
Consultations	T2025		each
Parenting Support	S5120		15 min
Community Transition Services	T5999		each

- **DD Provider –Professional Claim Submission**

  For DOS after 1/1/2020, all services, except for ICFs, must be submitted using a professional claim form. If you choose to do your own billing, outside of Therap, you will be required to enter claims on this claim type which requires an NPI, taxonomy, place of service, billing and rendering provider, a primary diagnosis, etc. If you use Therap for billing, all these items will be prepopulated for you.

- **Creating a Professional Claim**

  https://www.hhs.nd.gov/sites/www/files/documents/nd-mmis-web-portal-professional-claim-form-submission-instructions.pdf

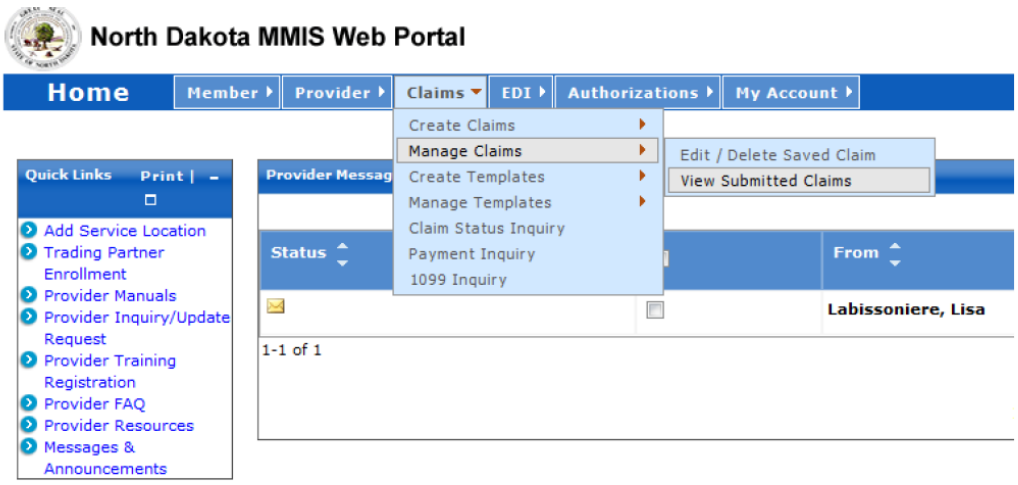
- **Creating a Claim Template**

  https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/training-mmis-portal-template-training.pdf

- **Submitting a Claim Adjustment or Voiding a Claim**
  - https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/training-mmis-portal-adjust-void-claim.pdf

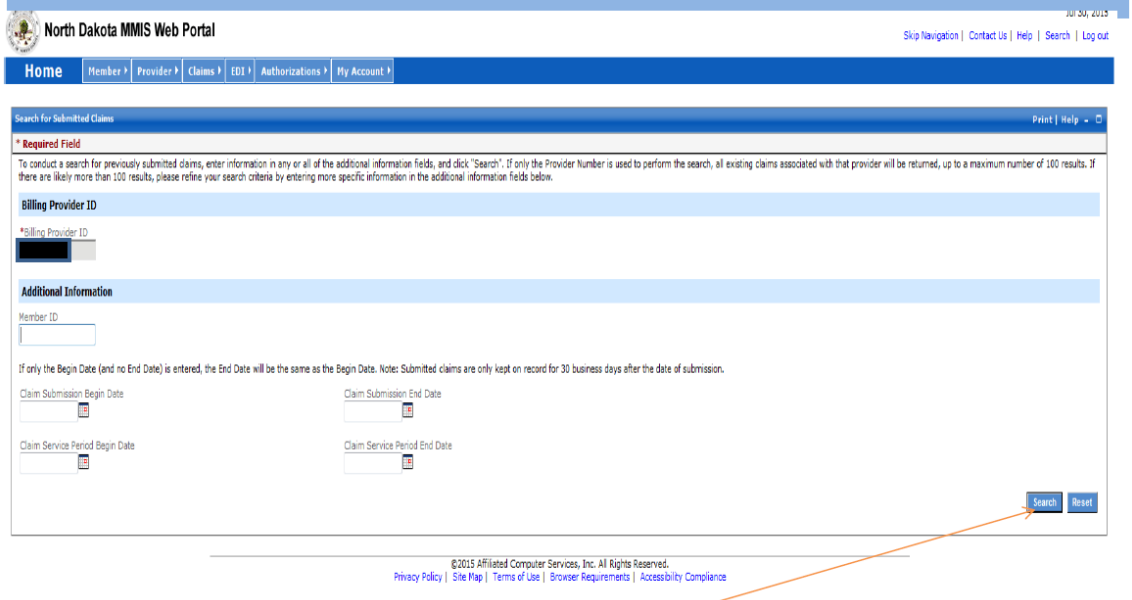
- **Submitting an Attachment to a Claim**
  - **https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/training-mmis-portal-adjust-void-claim.pdf**

DD Provider – View Submitted Claims



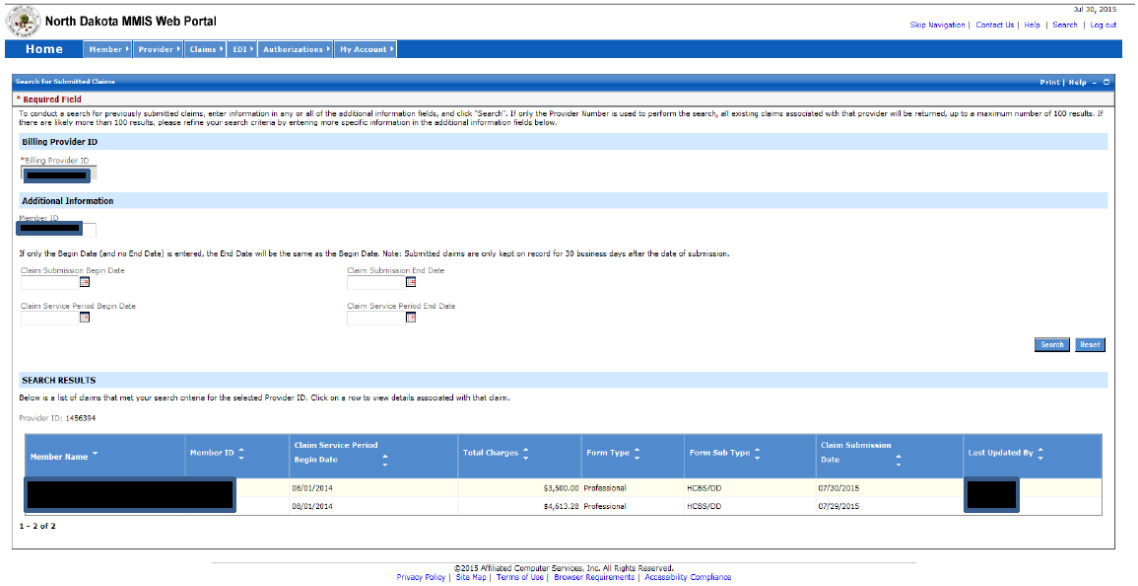
- To view a submitted claim go to **"Claims", "Manage Claims",** and **"View Submitted Claim"**.

DD Provider – View Submitted Claims



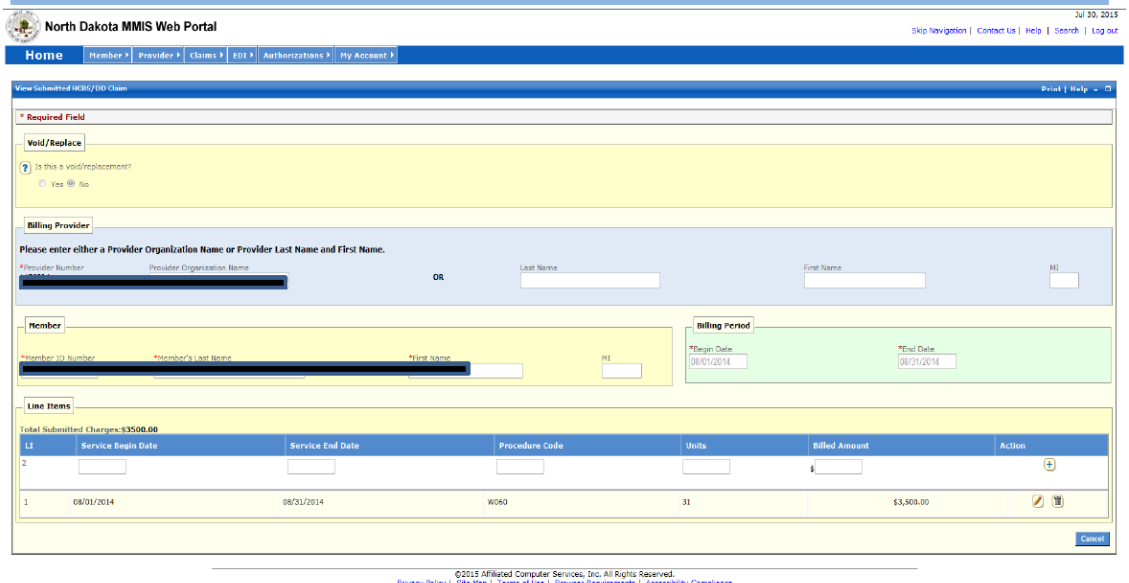
- Input the Member ID number and click on "**Submit**".
- There is an option to customize claim submission date ranges and claim service period date ranges. If this is desired enter the Member ID and the date ranges desired, then click on "**Submit**".

DD Provider – View Submitted Claims



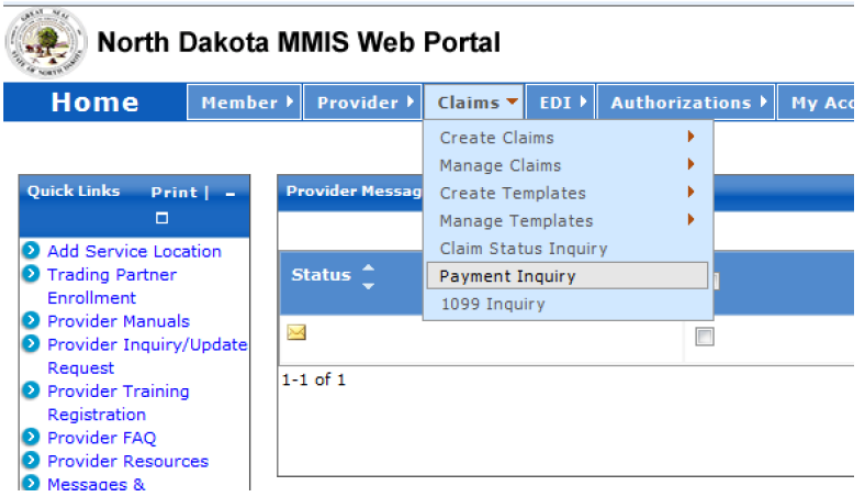
- If there is more than one submitted claim for the Member ID for the selected date range a list will populate. Select which claim you want to view by clicking on the blue hyperlink in the Member Name section. Due to HIPAA reasons this section has been blacked out.

DD Provider – View Submitted Claims



- The screen above will show once you select a claim from the list on the previous page.

DD Provider – View Remittance Advice



- To view a submitted claim go to **"Claims"** and **"Payment Inquiry"**.

DD Provider – View Remittance Advice

- Select desired date range for remittance advices (RA) and click on "**Select**".
- If there is more than one RA a list will appear. Select the RA you want to view by clicking on the blue hyperlink.

DD Providers – Common Remark Codes

Some Common Remark Codes

- MA133
  - Claim overlaps Inpatient Stay
- 204
  - This service/equipment/drug is not covered under the patient's current benefit plan
  - No DD waiver screening or Medicaid/Part C
- N129
  - Not eligible due to Member's age
- 26
  - Expenses Incurred prior to coverage
  - No Medicaid for the dates of service billed
- 27
  - Expense incurred after coverage terminated
  - No Medicaid for the dates of service billed
- 16/A1
  - Claim/service lacks information or has submission/billing errors
  - You do not need to pay attention to this code. It is only an accompanying remark.
- N54
  - Claim information is inconsistent with pre-certified/authorized services.
- N820
  - Unmatched Units- The EVV units billed, no not match the EVV data received by the aggregator.
  - If billing outside of Therap, check rounding rules.
  - Check data in Therap to ensure all visits for the day are in accepted/sent status to aggregator.
- N821
  - No Visit Found- EVV visit not found in the aggregator.
  - Check data in Therap to make sure it is in sent status.
  - Check data in Therap to ensure all visits for the day are in accepted/sent status to aggregator.
- 198/119

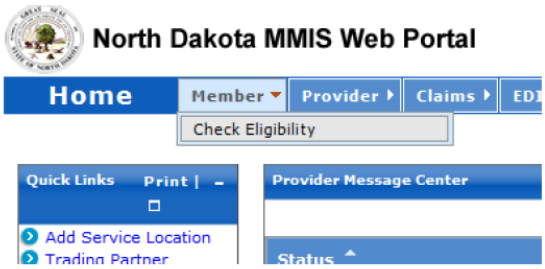
    - Precertification/authorization exceeded/Benefit maximum for this time period or occurrence has been reached.
    - Check preauth/authorization for Units authorized
    - Contact ddclaimsupport@nd.gov if the amounts you have billed are less than the approved authorized amounts

- Full list of denial codes can be found: https://x12.org/codes
    - There is a link for reason codes and remark codes that will provide an explanation.

- There may be more than one Remark Code assigned to a claim on the Remittance Advice.

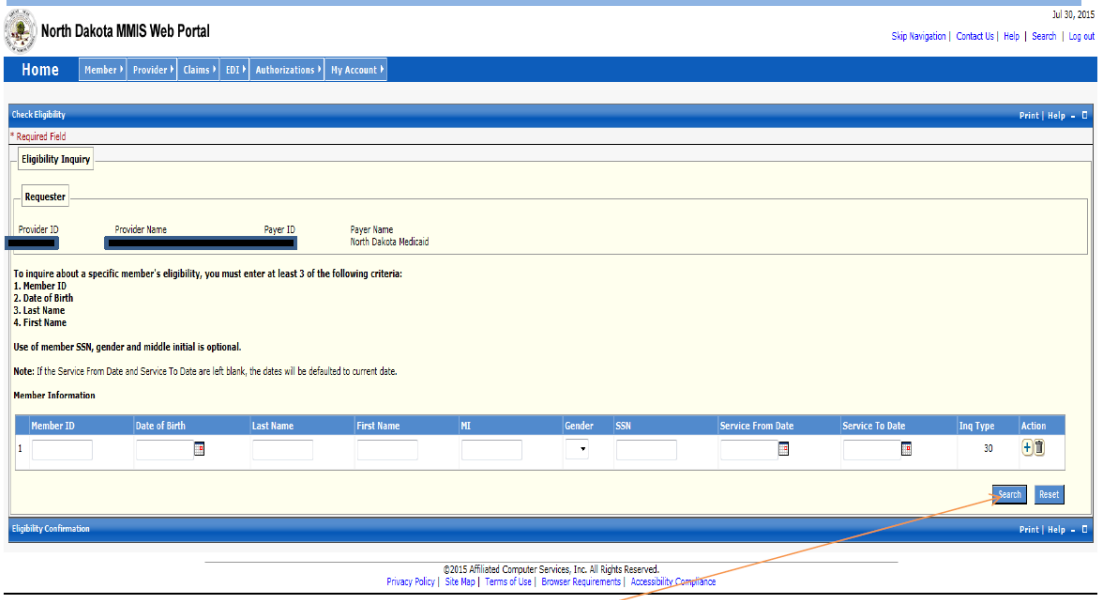
- All Billing and Case Action questions should be sent to ddclaimsupport@nd.gov

DD Provider – Member Look up



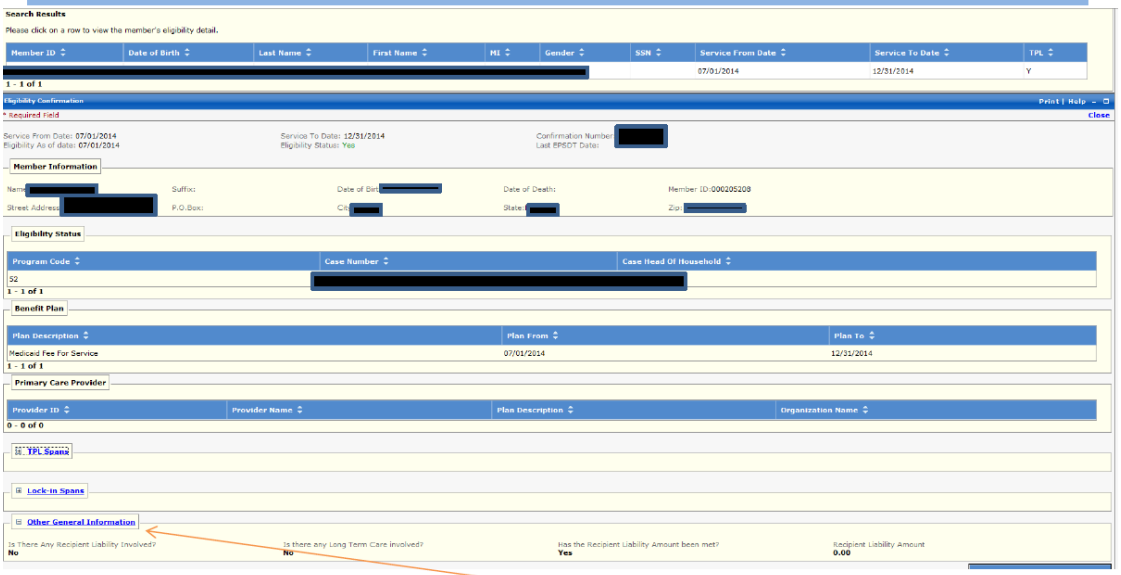
- To check for client eligibility for Medicaid and the amount of Recipient Liability (RL) select "**Member**" and "**Check Eligibility**"

DD Provider – Member Look up



- Enter the member ID, date of birth, last name, first name, and dates of service to view eligibility and click on "**Search**".

DD Provider – Member Look up



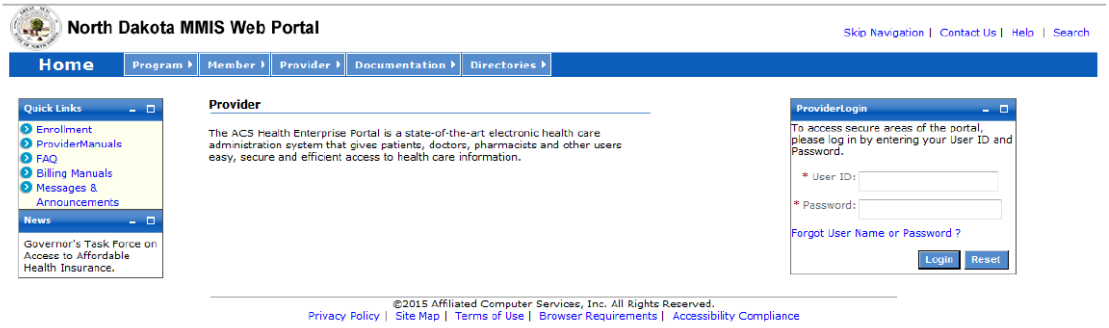
- Recipient Liability information is shown in the "**Other General Information**" section.
- The AVRS phone system can also be used to receive this information.

Intermediate Care Facilities (ICF) Billing Instructions for Completing the UB04 Claim Form via MMIS Web Portal

Intermediate Care Facility (ICF) Web Portal Billing Instructions

- In the "Sign In" block, select "Providers"

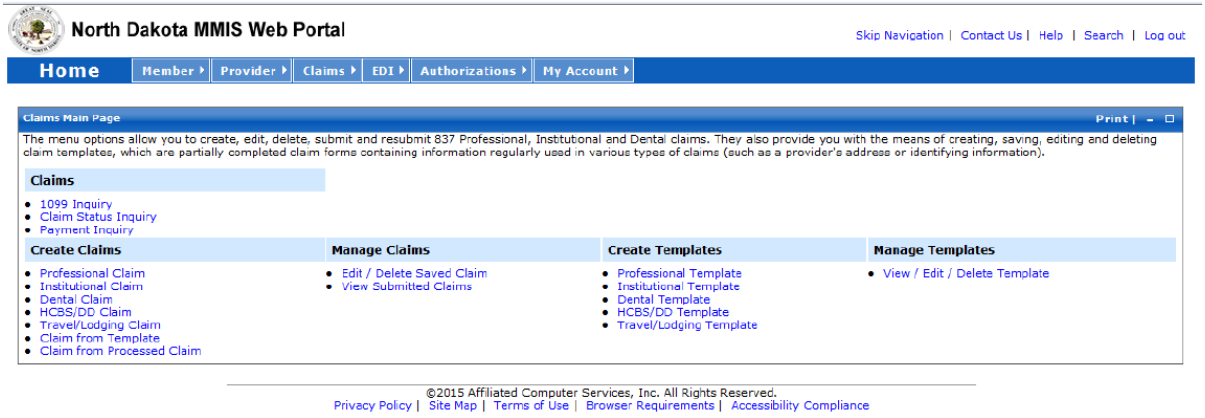
Intermediate Care Facility (ICF) Web Portal Billing Instructions



- Enter your User ID and Password
- Select "Login"

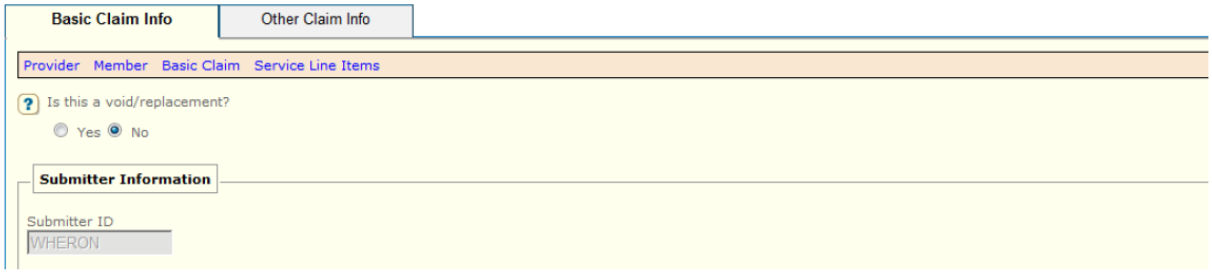
- Select the option you want to perform
- For Claims Entry
  - Click on the "Claims" tab on the menu line

Intermediate Care Facility (ICF) Web Portal Billing Instructions



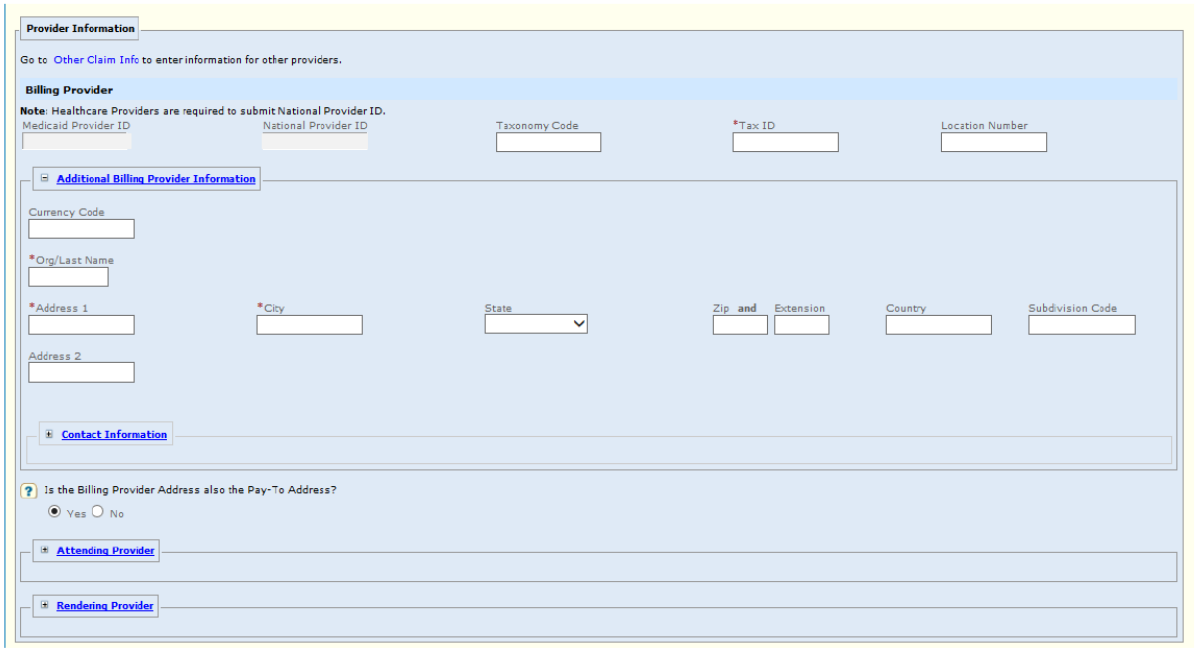
- Under the heading "Create Claims" select "Institutional Claim"

Intermediate Care Facility (ICF) Web Portal Billing Instructions

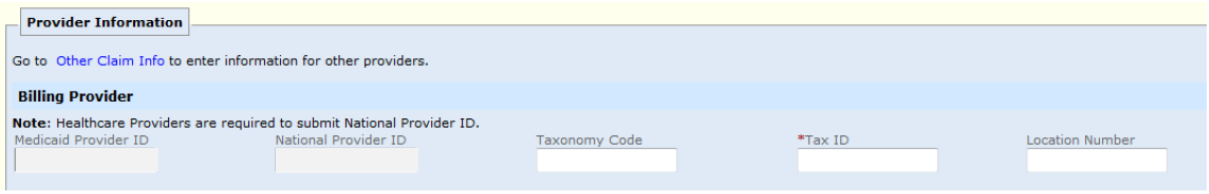


- The "New Institutional Claim" screen will appear
  - Is this a void/replacement?
  - This field will default to "No." Select "Yes" **only** if you are voiding or replacing a previously processed claim.
- Submitter Information
  - This section will auto-fill with your user information based on your User ID

Intermediate Care Facility (ICF) Web Portal Billing Instructions

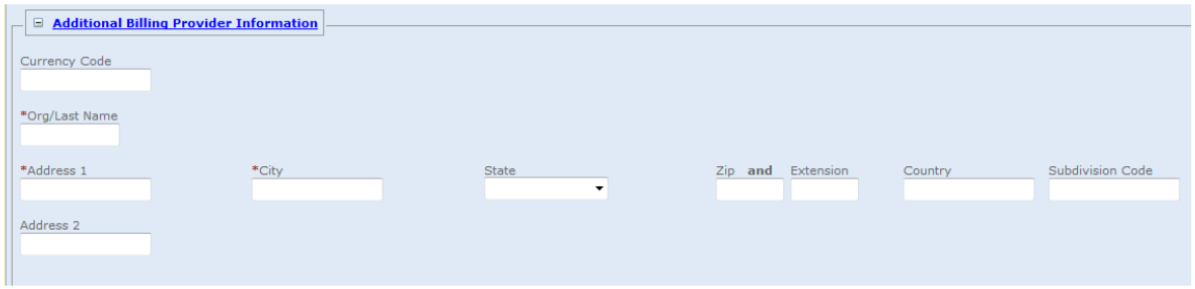


Intermediate Care Facility (ICF) Web Portal Billing Instructions



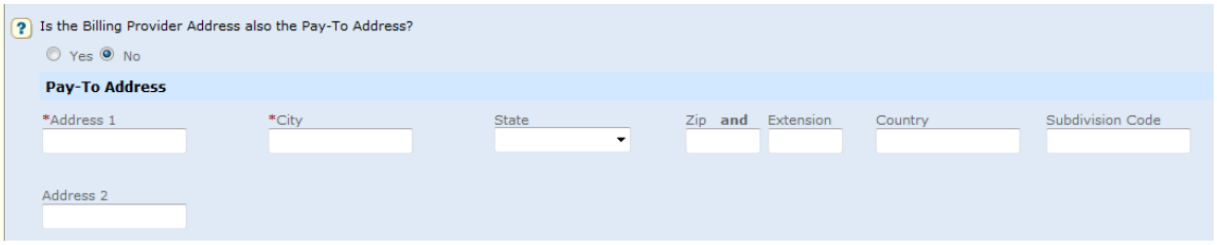
- Billing Provider
  - **REQUIRED**
  - Medicaid Provider ID and National Provider ID will auto-fill based on your User ID
  - Enter the Intermediate Care Facility (ICF) Taxonomy Code **315P00000X**
  - Enter your Tax ID
  - Enter the Location Number **BI** (Billing)

Intermediate Care Facility (ICF) Web Portal Billing Instructions



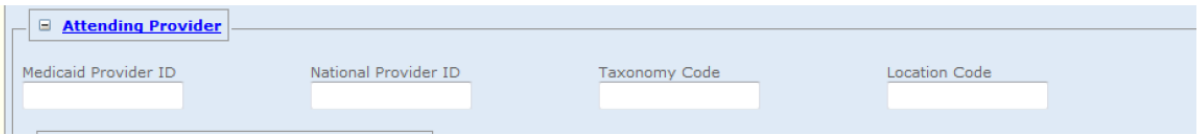
- Additional Billing Provider Information
  - **REQUIRED**
  - Enter your facility name, address, city, state, and zip code

Intermediate Care Facility (ICF) Web Portal Billing Instructions

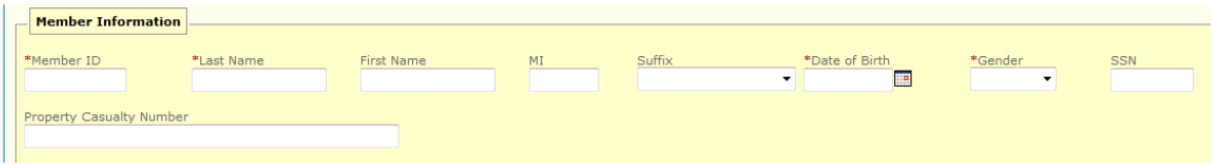


- Is the Billing Provider also the Pay-To Address?
  - Will default to "Yes"
  - If Pay-To Address is different, select "No"
  - Complete the Pay-To Address section with the facility name, address, city, state, and zip code

Intermediate Care Facility (ICF) Web Portal Billing Instructions

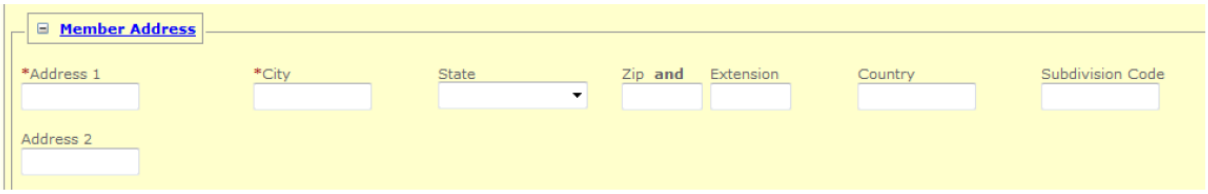


- Attending Provider
  - **REQUIRED**
  - Enter the Attending Provider's Medicaid Provider ID
  - Enter the Attending Provider's NPI
  - Enter the Attending Provider's Taxonomy Code
  - Enter the Location Code **AT** (Attending)

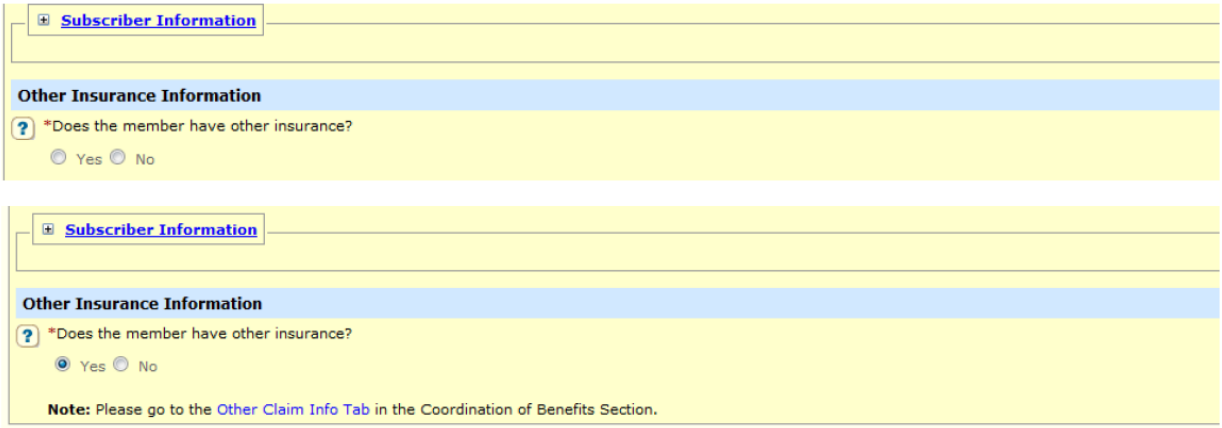


- Member Information
  - **REQUIRED**
  - Enter the member's 9-digit ID number (Do not use spaces, - , or /.)
  - Enter the member's last name
  - Enter the member's first name
  - Enter the member's date of birth
    - Use format: MM/DD/YYYY
  - Enter the member's gender
    - F = Female
    - M = Male

Intermediate Care Facility (ICF) Web Portal Billing Instructions

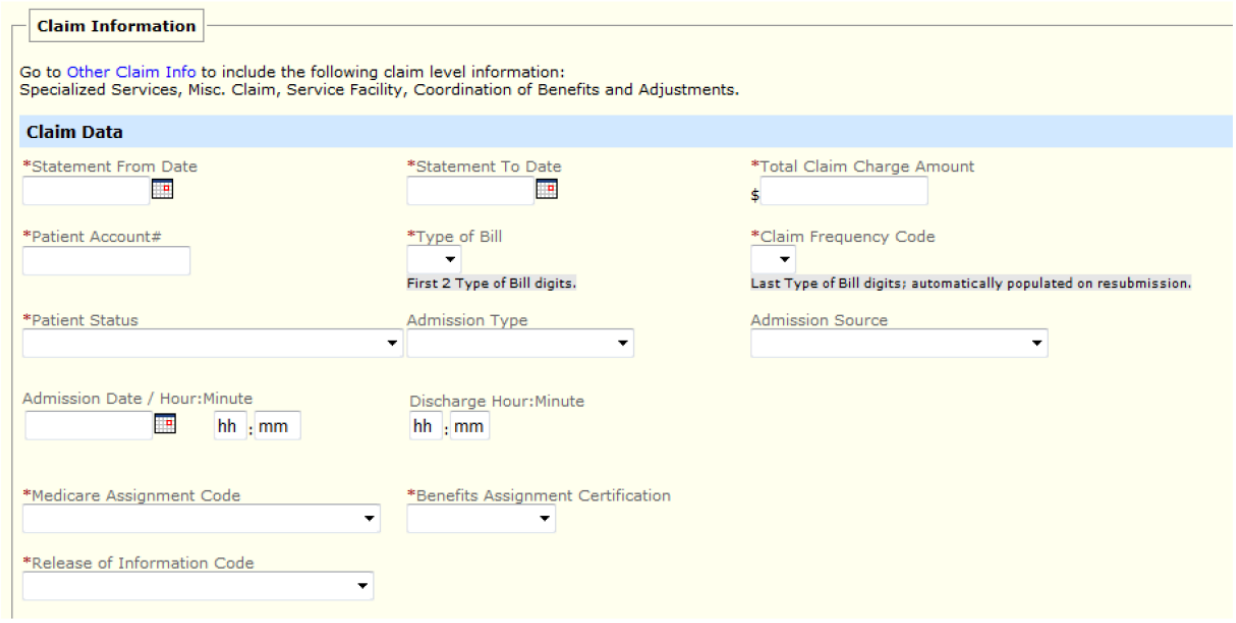


- Member Address
  - **REQUIRED**
  - Enter the member's address, city, state, and zip code



- Other Insurance Information
  - **REQUIRED**
  - Does the member have other insurance?
  - Select "Yes" or "No"
  - If you select "Yes" you must complete the Other Claim Info tab with the Other Insurance information

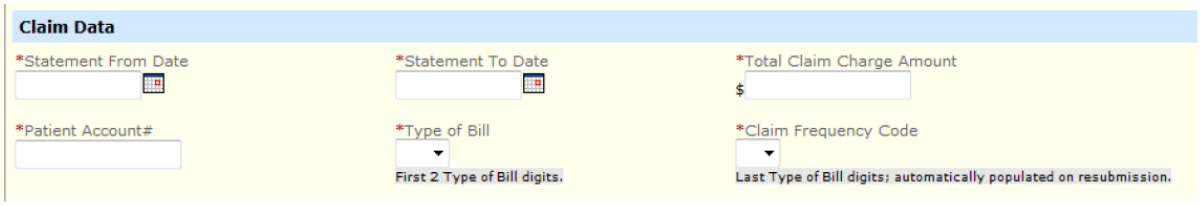
Intermediate Care Facility (ICF) Web Portal Billing Instructions



Intermediate Care Facility (ICF) Web Portal Billing Instructions

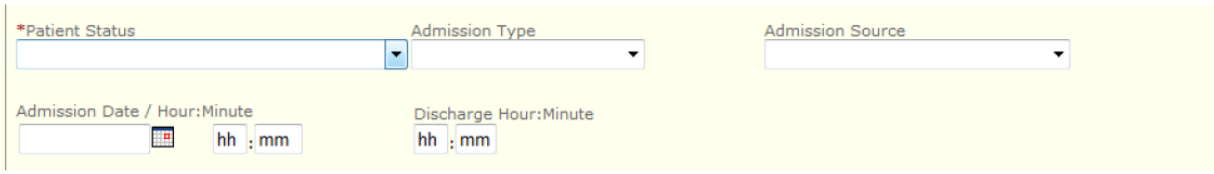
- Claim Information - Bill for only one (1) month at a time
  - **REQUIRED**
  - Statement From Date
    - Use format: MM/DD/YYYY
  - Statement To Date
    - Use format: MM/DD/YYYY
  - Total Claim Charge Amount
    - Enter the total amount billed

Intermediate Care Facility (ICF) Web Portal Billing Instructions



- Claim Information (continued)
  - **REQUIRED**
  - Patient Account #
    - Enter the internal patient account number
  - Type of Bill
    - Select **21** for Intermediate Care Facility
  - Claim Frequency Code
    - Select the last digit 1-8 for the specific bill type
    - See “Bill Type List” pages 26-28

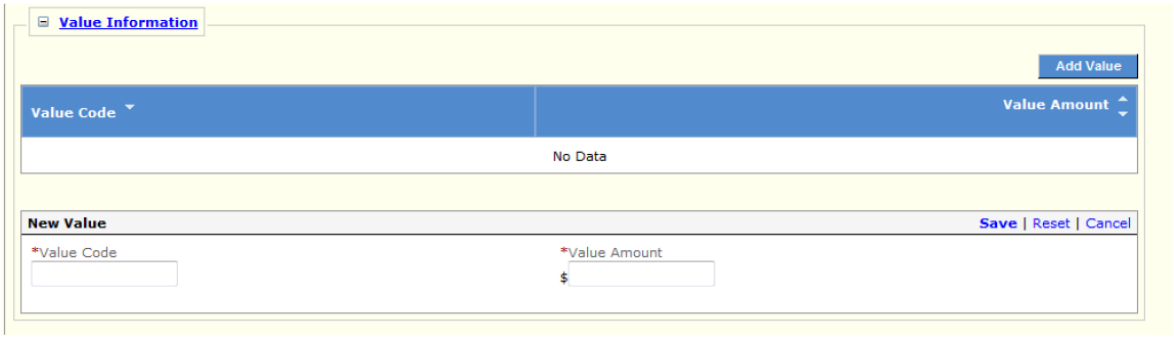
Intermediate Care Facility (ICF) Web Portal Billing Instructions



- Claim Information (continued)
    - **REQUIRED**
    - Patient Status
        - Select the appropriate status from the dropdown menu
    - Admission Type
        - Select the appropriate type from the dropdown menu
    - Admission Date/Hour:Minute
        - Use date format: MM/DD/YYYY
        - Use military format: HH:MM
        - Example: 4:15pm = HH:MM = 16:15
    - SITUATIONAL – Discharge Hour:Minute
        - If patient is other than "Still a Patient" you **must** enter the hour:minute patient was discharged
            - Use military format: HH:MM
            - Example: 4:15pm = HH:MM = 16:15

Intermediate Care Facility (ICF) Web Portal Billing Instructions

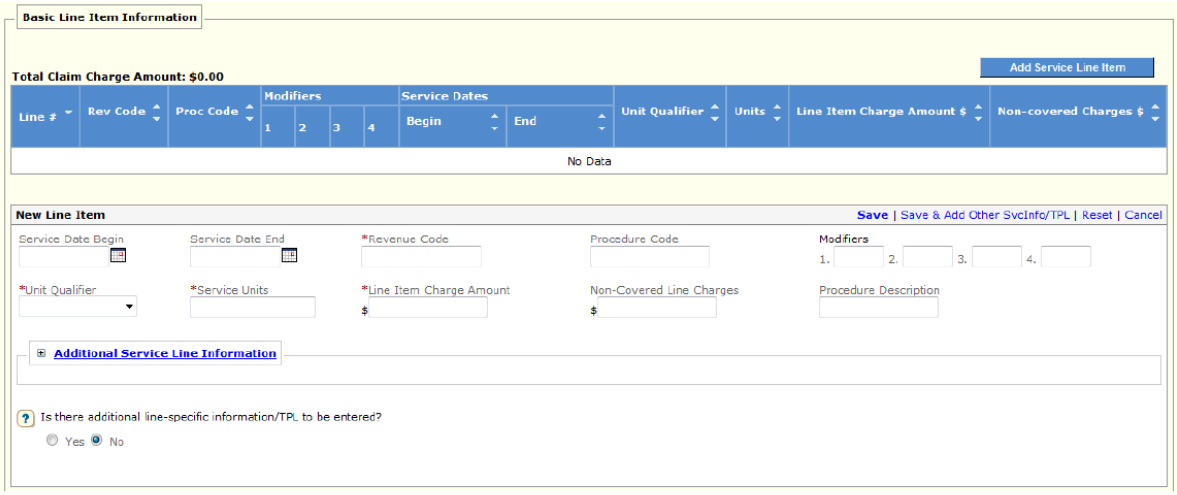
- Claim Information (continued)
    - **REQUIRED**
    - Medicare Assignment Code
        - Select the appropriate code from the dropdown menu
    - Benefits Assignment Certification
        - Select the appropriate response from the dropdown menu
    - Release of Information Code
        - Select the appropriate code from the dropdown menu



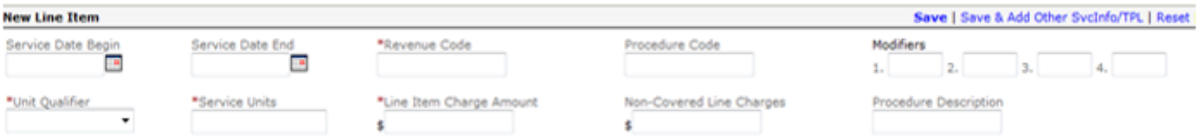
- Value Information
  - **REQUIRED**
  - Click on the "+" next to the heading
  - Enter the value code **80** and/or **81**
    - 80 = Covered Days
    - 81 = Non-Covered Days
    - Value Code 80 should equal the sum of the revenue code units
  - Enter the value amount
    - Value amount should be entered as a dollar amount
      - Example: 30 days = 30.00
  - SAVE value
    - Click on "Save" at the top right of the section

Intermediate Care Facility (ICF) Web Portal Billing Instructions

- Diagnosis Information
  - **REQUIRED**
  - Click on the "+" next to the heading
  - Version #
    - 09 – Ninth Revision (ICD-9-CM)
    - 10 – Tenth Revision (ICD-10-CM)
  - Principal Diagnosis Code
    - Enter the diagnosis code for the member's primary condition
      - ICD-9 codes for date(s) of service prior to September 30, 2015
      - ICD-10 codes for date(s) of service on or after October 1, 2015

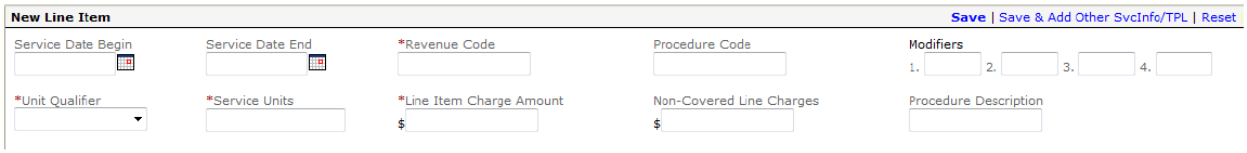


Intermediate Care Facility (ICF) Web Portal Billing Instructions



- Basic Line Item Information
  - **REQUIRED**
  - New Line Item
    - Service Date Begin
      - Use format: MM/DD/YYYY
    - Service Date End
      - Use format: MM/DD/YYYY

- Revenue Code
  - Must be 4 digits
    - 0110 In-House Medicaid Days
    - 0180 Therapeutic Leave Days
    - 0185 Hospital Leave Days



- Basic Line Item Information (continued)
  - **REQUIRED**
  - Unit Qualifier
    - Select DAYS as the appropriate unit from the dropdown menu
  - Service Units
    - Enter the number of units for the revenue code
    - The number of units billed must include the day of discharge or death
    - A separate line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed
  - Line Item Charge Amount
    - Enter the total charges for the line item
  - SAVE LINE ITEM – small SAVE at the top right of the New Line Item Section
  - If there is more than one line item to be billed, select "Add Service Line Item" and follow the above instructions
  - Enter each line item separately and SAVE each line item before entering a new line item

Intermediate Care Facility (ICF) Web Portal Billing Instructions

- When all information is entered on the claim , click "SUBMIT CLAIM" at bottom right

Intermediate Care Facility (ICF) Web Portal Billing Instructions

Bill Type List

• 1	Admit through Discharge Claim	This code is to be used when a member is admitted and discharged in the same month. Member CANNOT be in the "Still a Patient" status.
• 2	Interim – First Claim	This code is used for the first claim and the Discharge Status (fld17) as "Still a Patient.
• 3	Interim – Continuing Claim	This code is used for the second and any ongoing months that have a Discharge Status (fld17) as "Still a Patient".
• 4	Interim – Last Claim	This code is used for the Final claim billed for the member.

Intermediate Care Facility (ICF) Web Portal Billing Instructions

• 7	Replacement of Prior Claim	A claim replacement may be submitted to modify a previously processed claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below: Field 4: Use 7 as the last digit in the Type of Bill Code Field 64: Enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN)

If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

Example:
Legacy ICN: 101515320010
Replaced Legacy ICN: 10**20**15015320010

•	8 Void/Cancel of Prior Claim	Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below: Field 4: Use 8 as the last digit in the Type of Bill Code Field 64: Enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN)

If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

Example:
Legacy ICN: 101515320010
Replaced Legacy ICN: 10**20**15015320010

SECTION XVI – LICENSING HANDBOOK & FORMS – APPENDIX D

LICENSING FORMS

The following is a brief explanation of each of the forms used in the licensing review process. In general, these guidelines apply to all the forms utilized:

- All requests for single signature/title dates refer to the individual completing the form, generally the agency's chief executive officer.
- Additional sheets may be attached to provide additional information.
- Photocopies of forms may be made, as necessary.

All forms can be found at https://www.nd.gov/eforms.

Criminal Offense Conviction Statement (SFN 235)
A two-part form which certifies that either no staff or board member has been convicted of an offense or lists those, that has a conviction record. Applicant completes only the appropriate section.

Financial Disclosure Statement (SFN 236)
A two-part form, which certifies the board member, does not have any financial relationship with the agency or delineates that relationship. Each board member must complete only that appropriate section when they begin their term on the board, or as changes develop (does not have to be submitted annually).

Fire Inspection Certification (SFN 223)
Completed by the appropriate fire authority following the required National Fire Protection Association Life Safety Code chapter (as specified in NDAC 75-04-01-23). If deficiencies are cited, confirmation of completion and date of corrections must be shown by the agency Chief Executive Officer (under agency confirmation column).

Governance Statement (SFN 1549)
Lists the presiding official and other governing board officers/directors. Term dates refer to dates, which that individual has agreed to serve. Consumer or consumer representative refers to their relationship to individual served (either is developmentally disabled or is related to the third degree of kinship to someone with developmental disabilities). May be used to report Advisory Board members, if applicable.

Insurance Coverage Statement (SFN 234)
Requests all information pertinent to the agency's operation (as specified in NDAC 75-04-01-38).

License Application Checklist (Day/Residential) (SFN 1552)
Lists all requirements for licensure and dates, which they have been submitted. Intended for licensing review use and serves as the guideline for the service provider to determine compliance.

License Termination Request (SFN 1550)
Required for termination of any day or residential service(s). List each service being discontinued with

the address of the facility involved and the number of individuals in that service, as well as the effective date of termination. Include in the rationale the reasons for which the agency wishes to discontinue the service(s).

Medicaid Program Provider Agreement (SFN 615)
To be completed by the service provider prior to rendering any service to Medicaid individuals.

Developmental Disabilities Provider Addendum (SFN 569)
To be completed by the service provider prior to rendering any service to Medicaid individuals.

North Dakota Developmental Disability Provider Application (SFN 1794)
Must be submitted for all renewal, changes, or new services. Signatures required are either governing board head or chief executive officer for the agency. Accreditation/certification refers to accreditation agency or Department of Health and Human Services – Health Facilities Unit (for Title XIX) certification. Individual numbers refers to the occupancy of that location whether day/work or residential setting.

North Dakota Developmental Disabilities Provider Letter of Intent Application (SFN 1793)
Must be submitted for all renewal, changes, or new services. Signatures required are either governing board head or chief executive officer for the agency. Accreditation/certification refers to accreditation agency and for ICF/IID the Centers for Medicare and Medicaid (CMS). Individual numbers are requested for each site whether day or residential. The Regional Developmental Disabilities Program Administrator must approve applications for changes in licensure status.

Ownership/Controlling Interest and Conviction Information (SFN 1168)
To be completed by the service provider outlining key management positions, i.e. CEO, CFO, COO, Business Managers, etc. If the service provider is a corporation, the Board of Directors section must also be completed.

Physical Standards Checklist (SFN 1555)
Delineates those requirements for group homes as mandated in the Implementation Order of March 6, 1984 and is conducted by licensing review during an initial survey.

Plan of Correction (SFN 1556)
To be completed by the service provider within ten (10) days of notice of noncompliance (during review process).

Policies and Procedures Checklist (SFN 1544)
Provides assurance that the agency has approved and is implementing those policies as described in NDAC 75-04-01-20.

Provider Assurance to the Federal Home and Community Based Services (HCBS Regulations) (SFN 1010)
To be completed by the service provider to certify the provider has read and understands their responsibilities as a provider to comply with the Home and Community Based Services (HCBS) regulations.

All completed forms should be forwarded to:

Licensing Program Administrator
ND Dept of Health and Human Services
Developmental Disabilities Section
1237 W Divide Ave Ste 1A
Bismarck, ND 58501-1208
dhsddreq@nd.gov

TIMELINES FOR THE SUBMISSION OF FORMS

Licensure Forms	Submitted
Criminal Offense Conviction Statement	Initial licensure & annually for license renewal
Financial Disclosure Statement	Initial licensure & annually for license renewal
Fire Inspection Certification	Initial licensure & annually for license renewal
Governance Statement	Initial licensure & annually for license renewal
Insurance Coverage Statement	Initial licensure & annually for license renewal
License Application Checklist	Initial licensure
Medicaid Program Provider Agreement	Initial licensure & annually for license renewal
Developmental Disabilities Provider Addendum	Initial licensure
ND DD Provider Letter of Intent	Initial licensure
ND DD Provider Application	Initial licensure, license renewal & bed changes
Ownership/Controlling Interest & Conviction	Initial licensure & as any changes occur
Physical Standards Checklist	Initial licensure
Plan of Correction	Initial licensure & as needed
Policies and Procedures Checklist	Initial licensure & as any changes occur
Provider Assurance to the Federal Home and Community Based Services (HCBS Regulations)	Initial licensure & annually for license renewal