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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

A. The **State** of **North Dakota** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of ?1915(c) of the Social Security Act.

B. Program Title:
North Dakota Medicaid Waiver for Medically Fragile Children

C. Waiver Number:ND.0568

D. Amendment Number:

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

11/01/25

Approved Effective Date of Waiver being Amended: 06/01/21

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

To increase the age of waiver from 18 to 21 years of age.
increase the maximum slots to 50 active 75 total.
increase year five cost estimates by the 2% increase established by legislation.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A ? Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
☒ Appendix B ? Participant Access and Eligibility	
☐ Appendix C ? Participant Services	
☐ Appendix D ? Participant Centered Service Planning and Delivery	
☐ Appendix E ? Participant Direction of Services	
☐ Appendix F ? Participant Rights	
☐ Appendix G ? Participant Safeguards	
☐ Appendix H	
☐ Appendix I ? Financial Accountability	
☐ Appendix J ? Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☒ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☒ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

A. The **State** of **North Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

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

North Dakota Medicaid Waiver for Medically Fragile Children

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Draft ID: **ND.004.03.02**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 06/01/21
Approved Effective Date of Waiver being Amended: 06/01/21

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under section 1915(b) of the Act.**
Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

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

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

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

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

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

☐ **A program operated under section 1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

☐ **A program authorized under section 1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of this waiver is to provide assistance for families who require long term supports and services to maintain their medically fragile child in the family home setting while meeting their child's unique medical needs. This waiver will reduce and prevent skilled nursing facility placements for children who are Medically Fragile.

Currently the only program management entities that cover the identified needs of this waiver are the Regional Human Service Centers DD program managers. However, other case management agencies or individuals who meet the minimum provider requirements are eligible to provide case management services.

Organizational Structure: The North Dakota Department of Health & Human Services, Medical Services section is the authorizing agency and will complete the Level of Care and oversee the Level of Need, along with maintaining the waiting list. IN addition the development of requirements, rules and policies operationalized are overseen by the Medical Services.

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the

Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

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

On the Medicaid Medical Advisory Committee members were notified of the State Medicaid Agency's intent to renew the Children with Medically Fragile Need's waiver.

On HHS sent a notice to all Tribal Chairman, Tribal Health Directors and IHS Representatives in ND notifying them of the intent to amend the waiver. Tribal organizations were notified that they could view the waiver on the DHS website or receive a copy upon request. The tribal consultation notification letter was also posted to the DHS website. https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/tribal-consult-medicaid-waiver-medically-fragile-children.pdf The required 30-day public comment period was provided. Public comment accepted from 06/01/2023 until 06/30/2023 at 5:00 pm CST. DHS provided opportunities for public comment on the amendment in the following manner: 1) The amendment and public notice was posted to the DHS website http://www.nd.gov/dhs/services/medicalserv/medicaid/waivers.html .

On , A press release was issued Statewide notifying the public of the opportunity for public comment. The public notice and press release included information on how to access the waiver application online or request a hard copy and contained information on how to submit public comments.
Press release can be found at

Public Notice can be found at: .

The public notice is posted in a public area at the Capitol.

The State received comments for the amendments and against the amendment of the waiver therefore no modifications to the waiver occurred because of public comments. Copies of public comments is available upon request.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Barchenger

First Name: Katherine

Title: Program Manager

Agency: ND Department of Health & Human Services

Address: 600 E Boulevard Ave

Address 2: Department 325

City: Bismarck

State: North Dakota

Zip: 58505-0269

Phone: (701) 328-4630 **Ext:** ☐ **TTY**

Fax: (701) 328-1544

E-mail: kbarchenger@nd.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: North Dakota

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements

specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Dakota**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

To prevent the need for a waitlist the number of participants will be 50 active 75 per year.

When the department is in need of a waitlist the individuals that are placed on the waitlist will have been screened for the waiver. The transition plan for the individuals from the waitlist to waiver slot will be as follows: Completion of a new Level of Care process to ensure the individual still has a need for waiver services. Once an individual has a slot, the individual will be assigned a case manager of choice, and a person-centered plan of care will be completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The North Dakota Department of Human Services acknowledges that there are legal and stakeholder partnerships with the Indian Tribes in North Dakota. These partnerships have grown throughout the years and will continue to be an integral part of implementing the revisions set forth by the American Recovery & Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA).

It is the intent of the North Dakota Department of Human Services to consult on a regular basis with the Indian Tribes established in North Dakota on matters relating to Medicaid and Children's Health Insurance Program (CHIP) eligibility and services, which are likely to have a direct impact on the Indian population. This consultation process will ensure that Tribal governments are included in the decision making process when changes in the Medicaid and CHIP programs will affect items such as cost or reductions and additions to the program. The North Dakota Department of Human Services shall engage Tribal consultation with a State Plan Amendment, waiver proposal or amendment, or demonstration project proposal when any of these items will likely have a direct impact on the North Dakota Tribes and/or their Tribal members.

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

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

a. Indian Affairs Commission Meetings
b. Interim Tribal and State Relations Committee Meetings
c. Medicaid Medical Advisory Committee Meetings
d. Independent Tribal Council Meetings

Ongoing Correspondence:
• A web link is located on the North Dakota Department of Human Services website specific to the North Dakota Tribes. Information contained on this link includes: notices, proposed and final State Plan amendments, frequently asked questions and other applicable documents.
• A specific contact at the North Dakota Department of Human Services Medical Services Division, in addition to the Medicaid Director, will be assigned for all ongoing Tribal needs. This contact information will be disseminated in the continuing correspondence with the North Dakota Tribes.
Content of the written correspondence will include:
• Purpose of the proposal/change
• Effective date of change
• Anticipated impact on Tribal population and programs
• Location, Date and Time of Face to Face Consultation OR If Consultation is by Written Correspondence, the Method for providing comments and a timeframe for responses. Responses to written correspondence are due to the Department 30 days after receipt of the written notice.

Meeting Requests:
In the event that written correspondence is not sufficient due to the extent of discussion needed by either party, The North Dakota Department of Human Services, the North Dakota Tribes, or Indian Health Services can request a face to face meeting within 30 days of the written correspondence, by written notice, to the other parties.

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

Disability Services Division, Developmental Disabilities Unit

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

The functions performed by the Division of Developmental Disabilities, when a family chooses this provider for case management services, are: 1) recommend budget needs for the next biennium. 2) per parent request Program Managers or Case Manager matched to qualified families. And 3) complete Authorization of services. These roles and responsibilities can be found in Policy 585-05-60-10. The designated State Medicaid Director delegates the oversight of these actions to the Central Office Program Manager within the roles and responsibilities stated in policy 585-05-60-05. Any changes or problems that are noted in the program are reported to the State Medicaid Director by the Children's Waiver Administrator on an as need bases, or if necessary, in person depending on the urgency of the issue.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

Agencies will be solicited through the ND Department of Health & Human Services. Request for proposal process and contracts awarded for the determination of Level of Care and for Fiscal Agent Services. At this time, the state has contracted with Veridian for the Fiscal Agent Services and with Maximus for the completion of the Level of Care.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

conducting waiver operational and administrative functions:

The ND Department of Health & Human Services, Medical Services section (Medicaid Agency representative) will monitor the contract for the determination of Level of Care and the ND Department of Health & Human Services. Disability Services section (state operating agency representative) will monitor the Fiscal Agent contracts.

Appendix A: Waiver Administration and Operation

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

Monthly and annual reports regarding number and timeliness of Level of Care Determinations will be reviewed. Every 6 months a quality assurance report will be reviewed to determine if Level of Care decisions were supported by appropriate documentation. Feedback will be solicited from staff working with the Level of Care Determination process to measure satisfaction with current contractor.

Fiscal Agent activities will be continually monitored by families and case managers through on-line individual balance sheet reports. The Department of Health & Human Services will also monitor monthly contract billings.

All contracts are routinely monitored following the Department of Health & Human Services contract oversight procedures.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care waiver eligibility evaluation	☒	☒
Review of Participant service plans	☒	☐
Prior authorization of waiver services	☒	☐
Utilization management	☒	☐
Qualified provider enrollment	☒	☐

Function	Medicaid Agency	Contracted Entity
Execution of Medicaid provider agreements	☒	☒
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of self-directed services correctly paid by the Fiscal Agent that are authorized on the waiver participants authorization. N: Number of self-directed services correctly paid by the Fiscal Agent that are authorized on the waiver participants authorization. D: All self-directed services paid by Fiscal Agent for waiver participants.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants' skilled nursing facility level of care determinations that were completed within three business days. N: Number of waiver participants' skilled nursing facility level of care determinations that were completed within three business days. D: Total number of skilled nursing facility level of cares determinations.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

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

b. Methods for Remediation/Fixing Individual Problems

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

It is the responsibility of State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance or amending the contract. Documentation is maintained by the State that describes the remediation efforts. The Central Office Administrator contacts the participant's family yearly to complete annual re-enrollment. At this time, it is discussed if the program is meeting the needs of the family. Any issues that are brought forward are discussed between the central Office administrator and supervisor within Medical Services to determine if this is a systemic problem or isolated issue.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☒	**Medically Fragile**	3	20	☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Family will also need to agree to self-directing waiver services for the child.

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

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

Specify:

Families will be made aware of maximum age limit upon enrollment in the Waiver. Program Managers / Case Manager will facilitate the development of a transition plan within the Case Plan by the time the child is 20 1/2 years of age. Examples of support options that may be considered include Medicaid State Plan Services, other Waivers, nursing facilities, vocational rehabilitation,1915i services, etc.

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

The limit was set after analysis of Cost Study data from the State's MMIS system and Blue Cross/Blue Shield of North Dakota, and historical data from the Developmental Disabilities system including Family Subsidy, Family Support Services/In-Home Supports, and Program Management, prior to Legislation mandate of program. 2023 Legislation session increased the cost limit to $25,300.00. This amount had not been increased since the start of the waiver.

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

◉ **The following dollar amount:**

Specify dollar amount: 25300

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Through the intake and referral process, support needs identified by the legally responsible caregivers of minor children, who have met the Level of Care criteria,and the Level of Need criteria, will be compared with the supports offered through the Waiver. If the Central Office Administrator determines that the child's current health and welfare needs cannot be assured, the family will be advised that they will not be referred to the Regional Program Management system or case management of parent choice for authorization of Waiver services. The family will be advised of their right to appeal.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following

safeguards to avoid an adverse impact on the participant *(check each that applies)*:

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

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

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

Requests for short term exceptions will be reviewed at the Central Office and may be granted quarterly if additional supports will prevent long term out of home placements in nursing facilities and funding is available within Waiver budget.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	25
Year 2	25
Year 3	50
Year 4	50
Year 5	75

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

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	25
Year 2	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	25
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The policy for admission to the waiver is 585-05-25 of the Children with Medically Fragile Needs program. Within this policy it states a child must be Medicaid eligible, must pass the Nursing Home Level of Care, and receive a minimum score on the Level of Need Criteria with Family Viewpoint. Families also must have a need for a waiver service not including case management.

A Level of Need determination score, would be obtained from Primary Physician for children who have passed the Level of Care. This form will be scored by the primary physician of the child and would look at care elements within the following areas: overall care, skin/physical management, metabolic, GI/feeding, urinary/kidney, neurological, respiratory, and vascular. The family viewpoint is completed by the family and may cover: daily schedule, areas child needs assistance (dressing, eating) out of home doctor-therapy sessions per day/ list of daily medications – how they are administered, how often do you need to call doctors during the day, and how may visits to the ER due to child's conditions, number of children in the home, any special needs of other children, parents work schedule, supports within the home and any other important details regarding the care of child and family. this is scored as either sent in or not. The child with the highest score will be placed on top of the waiting list. The higher the score would indicate the child has more needs.

The Program Manager or Case Manager will work with the family in the development of the person centered plan of care and the individualized waiver authorization. Finally once the authorization is approved through the Central Office, the family may begin to work with Fiscal Agent to complete the process of hiring their employees or selecting vendors for the service authorization.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**

(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  (*select one*):

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

    Specify:

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

    (*select one*):

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

      Specify percentage:

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

      Specify dollar amount:

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

    Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

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

○ **The following standard under 42 CFR § 435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

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

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

  Specify dollar amount: 677 The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**
  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a

personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

reasonable indication of the need for services:

i. Minimum number of services.

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

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

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

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

A Waiver service (not including Case Management) must occur at least on a quarterly basis. If a Waiver service is not received on a monthly basis, Case Management will monitor the individual's needs on a monthly basis and document their health and safety status.

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

Maximus

- ○ **Other**

Specify:

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

Personnel employed through the contract entity Maximus are Licensed Practical Nurses supervised by a Registered Nurse.

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

The Level of Care instrument used by the State is entitled Level of Care Determination form. The completed document must be approved by the contract entity screening team to support that the individual meets the nursing facility level of care, as defined in North Dakota Administrative Code (N.D.A.C.) 75-02-02-09.

Information is gathered by the Central Office Administrator within the Department of Health & Human Services. They will complete the Level of Care Determination form and either a determination is made by the contract entity by conference call or by mail notification. The contract entity forwards a copy of the determination response to the Central Office Administrator and to the legally responsible adult of the minor individual.

The same documentation/process is required for initial and yearly re-evaluation of Level of Care.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

Process is the same as for initial evaluations.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

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

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

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

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

The Case Management data system (Therap) in which Level of Care are entered and Case Action forms are completed automatically sets an alert when an initial Level of Care is entered. The alert is set for 12 months minus a day and remains in the system until a Level of Care is terminated or a re-evaluation/annual Level of Care is completed.

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

Copies of the Level of Care rating forms will be kept by the Medicaid State Agency. Electronic records of the Case Action will be stored in Therap.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of Level of Cares completed for all applicants prior to an individual receiving waiver services. N: number of Level of Cares completed for all applicants prior to an individual receiving waiver services. D: total number of applicants to the waiver.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of Level of Cares completed for all applicants to the program that are completed accurately, by the Central Office Program Manager. N: Number of Level of Cares completed for all applicants to the program that are completed accurately, by the Central Office Program Manager. D: Total number of waiver applicants.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

Performance Measure:
Number and percent of LOC determinations being completed by using the approved form and using LOC criteria accurately. N: Number of LOC determinations being completed by using the approved form and using LOC criteria accurately. D: total number of LOC's completed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Level of Care determinations made by a qualified evaluator. N: Number of Level of Care determinations made by a qualified evaluator. D: all level of cares completed for Children with Medically Fragile Needs.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

It is the responsibility of State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance or amending the contract. Documentation is maintained by the State that describes the remediation efforts. Data is recorded on any denied LOC and these denials are reviewed with the Central Office Administrator and supervisor to determine if the denial represents a systemic problem that require more holistic solutions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

A Person Centered Case Plan is developed with the family and all generic and waiver options explored.

Program Managers/Case Manager will complete a Case Plan in Therap indicating the outcomes the family wants to achieve, the formal and informal supports that will help them achieve those outcomes, and the waiver services they will receive. The Individual Service Plan allows the eligible consumers legally responsible caregiver to indicate they are in agreement of choosing Waiver services versus institutional care. The individual authorization document allows the eligible consumers legally responsible caregiver to indicate they have been informed of the right to appeal if dissatisfied or not in agreement with services.

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

Copies of the signed Individual Service Plans and individual service authorization will be kept in the regional Human Service Centers. Due to appeal rights of an individual, records are kept until three months past their 18th birthday - retention of records is age 18 plus six years.

Appendix B: Participant Access and Eligibility

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

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

When a consumer and/or their legally responsible caregiver is unable to independently communicate with the Central Office Administrator, their Program Manager/Case Manager or the Fiscal Agent, the services of an interpreter will be arranged. Written material may also be modified for non-English speaking consumers. The North Dakota Department of Health & Human Services has a Limited English Proficiency Implementation Plan to assist staff in communicating with all consumers.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Institutional Respite		
Statutory Service	Program Management or Case Management		
Extended State Plan Service	Dietary Supplements		
Other Service	Environmental Modification		
Other Service	Equipment and Supplies		
Other Service	In-Home Supports		
Other Service	Individual and Family Counseling		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Institutional Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The purpose of Institutional Respite is to provide temporary relief to the eligible consumer's legally responsible caregiver from the stresses and demands associated with having a child that is medically fragile. Institutional Respite is provided in a nursing facility or hospital which is capable of meeting the child's unique medical needs while assuring their health and welfare.

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

Institutional Respite can be provided for no longer than 14 consecutive days.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facility, Hospital

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Institutional Respite

Provider Category:

Agency

Provider Type:

Nursing Facility, Hospital

Provider Qualifications

License *(specify):*

Licensed to operate in North Dakota by the Department of Health

Certificate *(specify):*

Certified as a Medicaid Provider

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Department of Health

Frequency of Verification:

Annual Licensing

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Program Management or Case Management

HCBS Taxonomy:

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

Service Definition *(Scope):*

This service would assist the individual /family by providing information, referral, and support to them. Case management services would provide a variety of activities such as intake, case planning, on-going monitoring and review of supports and services to promote quality and outcomes, and planning for and implementing changes in supports and services and right of appeal. This service would assure that support for individual/family requests fall within the scope of programs, while promoting reasonable health and safety. Case management services would assist in the coordination of identifying multiple services both formal and informal, along with obtaining/ applying for identified services. This service would ensure goals and needs are being met by meeting with the individual/family at least quarterly to review case plan and assure supports are successful in reaching the goals of the family. Case management service would ensure the review of rights are signed to include the assurance of family being informed of their rights and to document the choice of services for individuals requesting a HCBS waiver verses Institutional care. Case management services would meet face to face with individual/family at least quarterly; this would include 1) review of progress 2) satisfaction with services, 3) identify barriers and 4) discuss an action plan to resolve outstanding issues. Case management services may consist of phone calls or accompanying consumer to supports agency assisting with completing paperwork and any other assistance identified in case plan. Case management service would be able to assist in crisis intervention services to include emergency planning. Case management would also provide emotional support and assistance to problem solving as needed. Case Management could also assist / participate in individual educational planning (IEP) process. Case Management would support/ educate families on the Self-Directed Supports program.

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

If Case Management Services are determined a need by the participant and family, service will be provided monthly to the family. This service does not meet the required use of a waiver service per quarter to remain on the waiver."

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Case Manager
Agency	Case Manager
Agency	Case Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Program Management or Case Management

Provider Category:

Individual

Provider Type:

Case Manager

Provider Qualifications

License *(specify):*

Holds a bachelors degree in any of the following: social work, psychology, nursing, occupational therapy, physical therapy,

child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreational therapy or human resources and administration and management. Or

Holds a masters degree counseling or doctorate in medicine

Certificate *(specify):*

Other Standard *(specify):*

Must have strong communication skills.
Must have personal licensures up to date.
Must be able to enroll as a Medicaid provider.
Must have a criminal background check completed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Central Office Program Manager

Frequency of Verification:

yearly

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Program Management or Case Management

Provider Category:

Agency

Provider Type:

Case Manager

Provider Qualifications

License *(specify):*

Holds a bachelors degree in any of the following: social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreational therapy or human resources and administration and management. Or
Holds a masters degree counseling or doctorate in medicine

Certificate *(specify):*

Other Standard *(specify):*

Must have strong communication skills.
Must have personal licensures up to date.
Must be able to enroll as a Medicaid provider.
Must have a criminal background check completed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Central Office Program Manager

Frequency of Verification:

yearly

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Program Management or Case Management

Provider Category:

Agency

Provider Type:

Case Manager

Provider Qualifications

License *(specify):*

bachelors degree in social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreation therapy, or human resources administration and management. A masters degree in counseling or a doctorate in medicine will also meet requirements.

Certificate *(specify):*

A Qualified Mental Retardation Professional (QMRP) A person who has as least one year of direct care experience working with persons with a mental illness or developmental disability; is a doctor of medicine or has a bachelors or masters degree in one of the following fields: social work, psychology, nursing, occupational therapy, physical therapy, child development and family communication disorders, severely multiply handicapped, special education, vocational rehabilitation, sociology, elementary education, recreation therapy, or human resources administration and management. A masters degree in counseling or a doctorate in medicine will also meet requirements. Show knowledge and understanding of Self-Directed Support program.

Other Standard *(specify):*

Requires knowledge, skills and abilities generally acquired and developed through formal education resulting in an undergraduate degree, extensive training, and /or relevant experience in work of an equivalent type and complexity. A moderaltly high degree of interpersonal skill is required to be able to communicate with and motivate others in the satisfactory performance of duties and responsibilities. The Ability to access the program ASSIST and to navigate said program. Ability to have contract with the fiscal agent for the spend down budget. Must have the ability to travel to the familys home throughout the state, as needed but at least quarterly. Must not have a conflict of interest in providing services to this population. Must be able to provide these services to the family at the same or less than rate.

Verification of Provider Qualifications

Entity Responsible for Verification:

Upon making application to the position of Case Manager the Human Resource Management Services a Division of the Office of Management and Budget, reviews and verifies the qualifications listed on the application. Those individuals that meet the requirements are then forwarded onto the interviewing team. Upon selection of appropriate individual: references are checked, if criminal history check is needed this is also completed.

Frequency of Verification:

Case Managers are subject to annual review of job performances and continued ability to meet qualifications for position. This review is completed by Program Administrator and is kept in the Case Manager's personnel file.
NDAC Chapter 4-07-10 covers the requirements for performance management and evaluations.
4-07-10-04: Each agency, department, and institution shall use the criteria in one or the other of the following performance management program types:
1. Individual-based performance.
a. Performance reviews are conducted at least annually.
b. Performance reviews are based on individual job-related requirements.
c. A standard form or approach is used.
d. Performance standards, or goals and objectives are used.
e. The review includes a review of past performance.
f. The review includes a discussion of how performance may be improved or how an employee's skills may be developed.
2. Team-based performance.
a. Performance reviews are conducted at least annually.
b. Performance reviews are based on overall team performance and how the employee functions as part of a team.
c. The emphasis of the program is on improving the quality of a service or product, constantly improving systems and processes, and on preventing problems and eliminating them.

d. The program provides guidance for the education, training, and self-improvement of the employee.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Dietary Supplements

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service is available when the child receives up to 51 percent of their nutritional intake from supplements or the supplement is disease specific. These supplements are products formulated to be consumed or administered to supplement oral intake as part of the overall medical management of a condition or disease. This would include supplements obtained through a feeding tube. Distinctive nutritional requirements based on recognized scientific principles are established by a medical evaluation. These supplements could also be used to produce therapeutic reactions to ameliorate or enhance the rate of recovery of certain conditions. This service would not support products such as herbs, botanicals or products where little or no scientific basis has been established, or those not prescribed for the specific dietary management of a disease or condition with distinctive nutritional requirements.

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

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy, DME Vendor, or other business that supplies product needed

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dietary Supplements

Provider Category:

Agency

Provider Type:

Pharmacy, DME Vendor, or other business that supplies product needed

Provider Qualifications

License *(specify):*

Licensed to practice their profession

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modification

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

To modify a family home and/or vehicle to enhance the eligible child's ability to function as independently as possible in their home and community.
An environmental modification provided to a participant must:
(a) relate specifically to and be primarily for the participant's Independence or assistance with ADL or IADLs;
(b) any modifications must be done primarily for the participant;
(c) not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
(d) not be in the form of room and board or general maintenance.
(e) not an item that would be covered under EPDST or Medicaid State Plan

This service covers purchases, installation, and as necessary, the repair of the following home modifications:
(1) Permanent Ramps
(2) Permanent lifts, elevators, manual, or other electronic lifts,
(3) Modifications and/or additions to bathroom facilities as related to letters a through e below:
a) Roll in shower
b) Sink modifications
c) Bathtub modifications
d) Toilet modifications
e) Water faucet controls
(4) Improve access/ease of mobility, excluding locks, as related to letters a through c below:
a) Widening of doorways/hallways,
b) turnaround space modifications,
c)floor coverings
(5) Specialized accessibility/safety adaptations/additions as related to letters a through f below:
a) Electrical wiring
b) Fire safety adaptations
c) Shatterproof windows
e) Automatic door openers/doorbells
f) Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant.

(6)Modifications and/or additions to kitchen facilities as related to letters a through c below:
a)Sink modifications
b)Water faucet controls
c)Counter/Cupboard modifications
(7) other non- listed modification to assist individual with independence of self or completion of ADL/IADLs - these modifications must have letter of recommendation from a professional on how item would meet these needs and needs and goals must be part of the person-centered plan.

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:
(1) Door modifications
(2) Installation of raised roof or related alterations to existing raised roof system to increase head clearance
(3) Lifting devices
(4) Devices for securing wheelchairs or scooters
(5) Handrails and grab bars
(6) Seating modifications
(7) Lowering of the floor of the vehicle

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

Modifications that cannot be moved to a new location are limited to the home owned by the family. Individuals must verify the home is structurally sound and modifications are not for maintenance care, but are to promote independence. Vehicle must have minimum insurance coverage required by state law. Vehicle must be owned by eligible child's legally responsible caregiver. Modifications must meet all ADA and local permit and safety inspection requirements.
All funds for modification must be within the budgeted $18,966.00 per individual.

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

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

☐ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual and Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification

Provider Category:

Individual

Provider Type:

Individual and Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

None

Verification of Provider Qualifications

Entity Responsible for Verification:

None

Frequency of Verification:

None

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized equipment, supplies, or safety devices that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These services would be outside of the scope of EPSDT. These goods must not be attainable through other informal or formal resources. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under EPSDT. Waiver would cover equipment to promote independence of identified participant, alternative power sources – i.e. generator, or clothing modifications, other items that are in addition to any medical equipment and supplies furnished under EPSDT. All items shall meet applicable standards of manufacture and design. Coverage may include the cost of maintenance and upkeep of equipment and may also include the cost of training the participant or caregivers in the operation and/or maintenance of the equipment

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

Authorized budget would need to remain under the waiver participants allotted amount for waiver services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual and Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Equipment and Supplies

Provider Category:

Individual

Provider Type:

Individual and Agency

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Participant and/or legal decision maker along with the team members will identify the appropriate equipment and supplies within the participants plan. The participant and/or legal decision maker will obtain the equipment and supplies from a provider who is enrolled with the ND Secretary of State and with the Fiscal Agent. The vendor must provide the item approved in the participant's plan

Verification of Provider Qualifications

Entity Responsible for Verification:

identified case manager/ program manager/ individual assisting family in meeting Case management needs.

Frequency of Verification:

quarterly

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

In-Home Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

In-Home Supports (IHS) enables a child who has a serious chronic medical condition to remain in and be supported in their family home and community. IHS is intended to support both the eligible child and the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible child must be living with a legally responsible caregiver. IHS benefits the eligible child by supporting their primary caregiver in meeting their unique medical needs and daily living needs. The primary care giver is supported in meeting the needs of their child within the routines of their family home and community: a)Training as identified in the Case Plan; b)Physical or verbal assistance to complete activities such as eating, drinking, toileting and physical functioning; improving and maintaining mobility and physical functioning; maintaining health and personal safety; carrying out household chores and preparation of snacks and meals; communicating, including use of assistive technology; learning to make choices, to show preference, and to have opportunities for satisfying those interests; developing and maintaining personal relationships; pursuing interests and enhancing competencies in play, pastimes and avocation; c)Involvement in family routines and participation in community experiences and activities. The eligible client will be supported in the home by staff hired by the family excluding legally responsible persons or individuals living in the same home as the consumer. The eligible client may also be supported in the home of the staff member hired by the family if the staff members home meet foster care licensure standards. This will not be a foster care placement, only the foster care standards will be used to assure health and safety welfare. Co-employers would be the family and an agency hiring the individual to work for family. Minimum requirements for a non-licensed provider would be 1) pass criminal background check, 2) over the age of 18, 3) not living in the home and 4) additional requirements identified on the individuals service plan.

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

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

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

☐ **Provider managed**

☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual and Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In-Home Supports

Provider Category:

Individual

Provider Type:

Individual and Agency

Provider Qualifications

License *(specify):*

The Family Support Services provider who are co-employers must be licensed as required in NDAC 75-04-01. (Co-employers would be family and agency both hiring the individual to work for family)

Certificate *(specify):*

Other Standard *(specify):*

Provider is required to meet the requirements of the state's Electronic Visit Verification (EVV) policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, Developmental Disabilities Unit with the assistance of fiscal agency completing/reporting the background checks and licensing requirement.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual and Family Counseling

HCBS Taxonomy:

Category 1: 10 Other Mental Health and Behavioral Services

Sub-Category 1: 10060 counseling

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Individual and/or family counseling to address needs related to the stress associated with the child's extraordinary medical needs which will support the continued integration of the child in their home and community. Currently the state plan covers counseling for individual/ family sessions if eligible consumer is present for sessions. The state plan also covers counseling by Psychiatrist or Psychologist if the eligible consumer is not in session. The waiver would cover sessions provided by other providers listed in the provider type, when the eligible consumer is not present.

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

This service will not be a duplication of what is available under State Plan option.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Counselor (Licensed Independent Clinical Social Worker)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual and Family Counseling

Provider Category:

Agency

Provider Type:

Counselor (Licensed Independent Clinical Social Worker)

Provider Qualifications

License *(specify):*

Licensed to practice their profession in North Dakota

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This waiver service will enable individuals to access essential community resources or services that are non-medical in order

to maintain themselves in their home and community.

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

Mileage for in and out of state travel would be reimbursed to parents of minor children who have financial responsibility, for access of services that are non-medical in nature. Per Diem will be reimbursed only when identified as a need in the individual's developed case plan, to assist with the possible but not limited to: high cost of transporting with specialty vehicles, or when limitation of freedom of choice occurs due to the rural environment/ limitations of choice. The driver must have a valid driver's license and show proof of minimum insurance coverage required by state law.

Must be identified on authorization, for lodging must have receipt, if travel by train or plane must have receipt. Valid driver's license and insurance sent to fiscal agent. The State reimburses at the "State's mileage rate" for transportation in state and out of state authorized trips.

Non-Medical Transportation reimbursement does not duplicate other transportations payments that maybe provided through informal supports or state plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify)*:

valid Driver's License

Certificate *(specify)*:

Other Standard *(specify)*:

Minimum vehicle insurance/ individuals completing services that are not a parent to the child will have background checks completed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agency

Frequency of Verification:

Annually

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

DD Program Management which are under the umbrella of the Department of Health and Human Services, completes the case management service which is also a waiver service. Once a DDPM position has been initially filled they receive training on the HCBSC settings rule through a course in PeopleSoft for new DDPMs when they are hired. Then all DDPMs take the course in PeopleSoft once a year in July. It gets sent out with 30 days for them to complete the course.

Person Centered Planning is trained on during a in person new DDPM Orientation which we offer twice a year in April and October for any new DDPMs that were hired in the previous 6 months. Training on Person Centered Planning for all new DDPMs during our Overall Service Plan (OSP) training that is offered twice a year in May and November for any new DDPMs that were hired in the previous 6 months. Both of these trainings are required for new DDPMs. The OSP training that is offered twice a year is also open to DDPM as a refresher if they want to take the course, but this is not required.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

When In-Home Support staff is hired by the family, staff must agree to give permission for a background check.
If the individual has lived in North Dakota for the last 5 years, a national check is not needed, only within state. If the individual has lived outside of North Dakota at any time during the last five years both the National and State check must be completed.
Veridian is responsible for conducting the background checks for all providers within the waiver. Once Veridian has completed the background check and all other requirements are completed successfully the family receives a “Good to Go” letter from Veridian for that provider to work with the participant.
A person who is providing self-directed in-home support must submit a criminal and background check application to the fiscal agent but will be allowed to start providing service BEFORE receiving the results of the criminal and background check. If the criminal or background check comes back with abuse, neglect, exploitation or a direct bearing offense per North Dakota Century Code (e.g. homicide, simple assault, robbery), the employer must cease use of the employee immediately.
The Fiscal Agent enters the new staff information into the protected spread sheet monthly of staff that have been cleared to work. If there is a direct baring offense, then an email is sent with the information for the program manager to make a determination if able to work.
Background checks are required to be completed for all respite staff that have been hired through an agency. Agency completes the background check.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Child Abuse and Neglect Information Index is maintained by the Department of Health & Human Services, Children and Family Services Section. All staff being hired by a family, or a licensed Family Support Services agency must give permission for an abuse registry screening.
Veridian is responsible for conducting the background checks for all providers within the waiver. Once Veridian has completed the background check and all other requirements are completed successfully the family receives a “Good to Go” letter from Veridian for that provider.
Continuity of care if participants service provider (in home support) has been added to the abuse registry will be looked at case by case - if participant has multiple providers approved, they will cover the hours that were removed from provider now on the abuse registry and service will continue as scheduled. If participant only had the one provider family will be offered the option to work with an agency provider who have approved staff or will be provided assists in finding another self-directed provide if participant wants to continue with self-directed and wait for a provider of thier choice to be approved.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives who are not legal guardians, not living in the same home as the eligible participant and does not have decision making authority may be paid for providing waiver services if they meet all other requirements.
The following service may be provided by a relative for payment; Self-directed In-Home Support. No payments may be made to a legal guardian, or any relative living in the home.
Authorizations are created based on team decisions regarding services that are in the best interest of the individual and that the relative working with individual is in the best interest of the participant. Medicaid payment system requires an appropriate level of care screening for the waiver, pre-authorize on the individual service plan, and current individual service authorization, and electric visit verification of visit in order for payment to be made within the specified timelines and limits.

The team includes the participant, participant's guardian or legal representative, case manager, provider program coordinator, other provider staff as needed, and anyone else the participant may choose.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Agency providers of In-Home Support must meet NDAC 75-04-01 to become a licensed Family Support Provider. The state responds to inquiries from potential providers and will solicit potential providers in areas with unmet needs. Any interested applicant may obtain a licensure packet through the Department of Health & Human Services and if they meet the minimum criteria, they will become a provider Family Support Services within MMIS.

Anyone who meets the requirement identified in the Service Plan and provider qualifications listed by service may be hired by the identified individual or their legal decision maker.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

◉ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☐ **The HCBS must be identified in the individual's person-centered service plan; and**

☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are**

not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

In home support is allowable to provide support both the eligible child and the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. Family may utilize In-home support staff to complete task that are of physical or verbal assistance to complete activities such as eating, drinking, toileting and physical functioning; improving and maintaining mobility and physical functioning; maintaining health and personal safety when theses task are over and above what Acute Care Hospital staff are required to provide. These tasks must be listed on the care plan and are reimbursed at same staff rate when in the home.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver providers who meet licensure/certification standards and adhere to other standards initially and continually. N: number of providers who meet licensing/certification standards and adhere to other standards initially and continually. D: all licensed/ certified providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of In-Home Support providers who successfully passed a criminal background check prior to first day of working with waiver participant. N: Number of In-Home Support providers who successfully passed criminal background check prior to the first day of working with waiver participants. D: Number of all In-home Support providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
review of provider file -determined by copy of letter from fiscal agent stating criminal background check was passed is within file

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all hospitals and nursing homes used by waiver participants for institutional respite licensed by the Department of Health. N:Number of hospitals and nursing homes used by waiver participants for institutional respite that are licensed by the Department of Health. D:Total number of hospitals and nursing homes used by participants for institutional respite.

Data Source (Select one):
Other
If 'Other' is selected, specify:
licensure checks when hospital or nursing home is used for institutional cares.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
Number and percent of non-licensed, non-certified waiver providers that meet service provider qualifications requirements of service provided. N: number of non-licensed, non-certified waiver providers who meet service provider qualification requirements of service provided. D: total number of non-licensed, non-certified waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
review of provider record

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percent of In-Home Support staff that meet training requirements. N: Number of In-Home Support staff that meet training requirements. D: Total Number of In-Home Support staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
program logs and or copy documented completion of training if available

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

It is the responsibility of State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance or amending the contract. Documentation is maintained by the State that describes the remediation efforts. The care plan is viewed by the Central Office Administrator and any additional training is reviewed to ensure completion and not a need for more holistic solutions. Identified areas of need are then discussed with Central Office Administrator and Director of Managed Care and Children's Services to determine if the individual problem represents a systemic problem that requires more holistic solutions.

Program logs are completed by case managers and provide an update of the progress being made towards goals stated within the care plan. These logs include updates/ completion dates/ any contacts made to family or providers. This is the document that holds the progress of the team. An example would be if a goal or task within the care plan states the In-home Support staff would have CPR training then the program log would have the progress history of getting this completed. The date the staff received CPR training, how this was verified or if the CPR training were postponed the reason why would be stated and the plan to complete the task of having In Home staff CPR trained. These logs are held within Therap system by the case manager.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is

authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Each specific participant is eligible based on needs up to $25,300.00 per state fiscal year. Any exception to increase the total annual budget will not exceed 10,000.00 per guidelines in B-2. 1. The individual's team completes an authorization based off of the identified needs of the participant. This authorization identifies the service and the quarterly cost of service. This authorization is then forwarded to the regional program director for approval followed by the Central office approval of services.

Families are informed of the $25,300.00 of funds for waiver services during the application process and within the acceptance letter to the program – All families have a case manager assigned to them to assist then with budgeting questions and to ensure they are aware of the limit of $25,300.00 and during quarterly meeting review with the family their remaining balance for the year.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

The setting in which waiver services are received are within the family home except for the institutional respite which is a short-term respite within a hospital setting - initiated by family as a maximum of two-week break for primary caregiver.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Participants for this waiver are serviced in their family home and not in a residential facility. This living arrangement is assured by home visits conducted by the case manager.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

◉ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a*

process in place to ensure:

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

A guide has been developed for families to explain the roles and responsibilities involved in self-directing supports. The guide was created by a parent representative at the North Dakota Center for Persons with Disabilities. Case Managers/Program managers will review the material with families, including the information that will be included in the Person Centered Service Plan regarding the Participant Centered Planning Process and assist the family in identifying who they would like involved in the development of the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. The Program Manager or Case Manager will work with the family to develop the Service Plan, the family will be assisted in identifying individuals that provide informal support and know their child and family very well and more formal supports they receive from agencies. The development of Individual Service Plan will be based on the guiding principles of individual and family involvement and consumer choice and control. The Service Plan will be a personalized, interactive and ongoing process to plan, develop, review and evaluate the services in accordance with the preferences and desired outcomes of the individual/family. The Program Manager or Case Manager will maximize the extent to which an individual/family participates in the service planning by: 1)Explaining to the individual/family the Service Planning process; 2)Assisting the individual/family to explore and identify their preferences, desired outcomes, goals, services and supports that will assist them in achieving their outcomes; 3)Identifying and reviewing with the individual/family issues to be discussed during service planning process; 4)Giving each individual/family an opportunity to determine the location and time of Service Plan meetings; participants in the Service Plan meeting; and number of meetings and length of meetings; and 5)offering families opportunities to speak with other families experiencing similar issues.

The family will determine who they want involved in developing the plan, but will be encouraged to include the input of their health care providers by either attending the meeting in person, by conference call or by providing recommendations in a written report. The initial Service Plan will be developed prior to a budget being developed and will be reviewed by at least the Program Manager or Case Manager and family quarterly and a new plan developed as needed but no later than a year minus a day from the previous Service Plan Meeting. Within 14 days following a Service Plan meeting, the Program Manager or Case Manager will complete the written Service Plan and provide the individual/family a copy of the plan.

B. The Program Manager or Case Manager, family and other members of the Service Plan team will review Level of Care and Level of Need documents, current medical reports and reports from other service providers working with the child and family, and will review the guide for families to develop a framework for assessment.

C. A brochure has been developed and is distributed to possible areas of referral, regularly. The types of services with definitions are as follows. The waiver services listed below are in addition to what the North Dakota Medicaid State Plan covers.
Transportation access to essential community resource or services.

Dietary Supplements: additional help when the child receives up to 51 percent of his/her nutrition from supplements or the supplements are disease specific.

Individual & Family Counseling: addresses needs related to stress associated with the care of child.

In-Home Support: temporary relief/assistance for the family, within the home, by a care giving assistant.

Equipment & Supplies: a service to purchase adaptive devices and supplies that can assist a child to stay home.

Environmental Modifications: modify home & vehicle for more independence.

Institutional Respite: temporary relief for family. Care provided in a facility that can care for the child's needs.

Case Management: a service to assist a family in completing case plan, emergency plan, and support to family as needed.

D. A written Individualized Service Plan will be developed, documenting:
1)The desired/preferred outcomes of the individual/family, and
2)Generic, natural services/supports that will assist the individual/family in achieving their outcomes regardless of funding source.
Written Individual Service Plans will be written initially and thereafter minimally once every quarter. This plan will cover waivered services to be utilized to enhance child's independence, desired and preferred outcomes of family/individual and address current health care needs and obstacles of reaching desired outcome. ie: surgery to prevent further difficulties from developing, plan would state what surgery, what needs to be in place for child to return home, and the estimated length of recovery needs.

E. The activities within the Service Plan will describe how the authorized services will integrate other related support plans such as an individual health plan, education plan, behavioral plan etc. and be consistent with other services provided in other environments such as community and school.

F. The Service Plan will include objectives and activities associated with the outcomes and describe specific roles and responsibilities of all parties including implementation of services and specific documentation requirements regarding delivery of services and activities performed. The Program Manager or Case Manager will review the Service Plan quarterly with the family to determine progress towards outcomes, satisfaction with services and to identify unmet needs. The person centered plan is signed by primary caregiver and identified individual is able, in addition the Program Managers and any other team member present signs the plan, next the authorization of service (cost listed) is developed and again this is signed by primary caregiver and program manager who oversees the services are being completed. Electronic signatures are accepted.

G. A new Service Plan is developed as needed but no later than a year minus a day from the previous Service Plan Meeting. The Service Plan may be amended at any time by the family and Program Manager or Case Manager through joint discussion, written revision and consent as shown by signature of the family. The family will have the responsibility to initiate a Service Plan meeting by contacting the Program Manager or Case Manager when the participants needs change, the Service Plan is not being carried out, when a change in service is desired or when a crisis develops. Program Managers or Case Manager will advise the family to contact them as soon as a change occurs so the plan can be updated at that time instead of waiting the three months for quarterly updates.

Interim service plans may be developed for consumers who require services immediately once Medicaid waiver eligibility has been determined, and the program management or Case Manager entity is not able to make a face to face visit on the day the service is requested. Interim service plans may also be developed for consumers who are affected by natural disaster or other emergencies who require services immediately once Medicaid waiver eligibility has been determined, or to ensure continuity of waiver services if the disaster occurs at the time the annual service plan needs to be reviewed and updated and the program management entity is not able to make a face to face visit as required. Interim service plans can begin the day that the consumer is found to be eligible for waiver services and cannot extend beyond the first 60 days of initial waiver eligibility, or the first 60 days of the annual service plan year, at which time the full comprehensive service plan must be implemented in order to continue the delivery and reimbursement of waiver services.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

With technical assistance through the central office, the Program Manager or Case Manager will assess with the family, the health and safety needs of the individual. The recommendations from health care providers and Level of Need documentation will be reviewed. The family will be made aware of their risks and responsibilities in self-directing supports to include the requirment of EVV for the service of In-home Support. A variety of generic community supports, as well as, formal and informal supports will be explored. The Service Plan will include emergency back-up plans to address what will happen if waiver or other support services are not available; the parents cannot carry out their role as their child's primary caregiver; or the family cannot remain in their home due to natural disasters, loss of electricity, or need to plan for obtaining special and critical items, such as medications, food, or equipment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Upon child being placed on waiver, family and Central Office Program Manager will discuss if they want to have either themselves as case manager or have a program manager/ Case Manager /someone else who can meet the families need of case management. If they decide to have someone else, options are offered; 1) case management through HSC or another qualified agency.2) someone they know that would be able to assist them in developing a plan and keeping track of paperwork/ services. They are also provided what the criteria would be for a case manager:
Service Activities:
1)assist the individual /family by providing information, referral, and support to them.
2)would provide a variety of activities such as intake, case planning, on-going monitoring and review of supports and services to promote quality and outcomes, and planning for and implementing changes in supports and services and right of appeal.
3)would assure that support for individual/family requests fall within the scope of programs, while promoting reasonable health and safety.
4)would assist in the coordination of identifying multiple services both formal and informal, along with obtaining/ applying for identified services.
5)would ensure goals and needs are being met by meeting with the individual/family at least quarterly to review case plan and assure supports are successful in reaching the goals of the family.
6)would ensure the review of rights are signed to include the assurance of family being informed of their rights and
7)to document the choice of services for individuals requesting a HCBS waiver verses Institutional care.
8)meet face to face with individual/family at least quarterly; this would include 1)review of progress 2) satisfaction with services, 3) identify barriers and 4) discuss an action plan to resolve outstanding issues.
9)Other interactions may consist of phone calls or accompanying consumer to supports agency assisting with completing paperwork and any other assistance identified in case plan.
10)would be able to assist in crisis intervention services to include emergency planning.
11)would provide emotional support and assistance to problem solving as needed.
12)could also assist / participate in individual educational planning (IEP) process.
13)Case Management would support/ educate families regarding their role and responsibility on self directing their childs services.

Since families self direct all other services it is their responsibility to find/ set up and oversee completion of waiver service. Program Managers or Case Manager can make suggestions or look into possible suggestions but it is the responsibility of family to interview/ hire and oversee completion of waiver service.

Program Managers or Case Manager will share information from a database of providers of family support services or nursing facilities and hospitals within the area. Families will be able to hire their own In-Home Support employees. Program Managers or Case Manager will share information with families on how to locate and hire their staff and select vendors. When a family has questions regarding locating specialized pediatric service providers, the Program Manager or Case Manager will assist with the resources they have available through Department websites and the technical assistance position.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Program Managers or Case Manager assisting the families in the development of the Service Plan are employees of the Department of Health & Human services. The Service Plan will be developed within the Therap system, which allows Program Managers or Case Manager to indicate authorization/approval of services funded through this waiver.
The Service plan that is developed within the Therap system is reviewed to ensure the practice of person-centered service planning has been utilized to include the wants and needs of the individual being served within waiver, this plan is reviewed at least every 12 months by the individuals team

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The assigned Program Manager or Case Manager will be responsible to monitor the implementation of the Service Plan and the participant health and welfare. The Program Manager or Case Manager will utilize the Quality Enhancement Review tool when they meet face to face with the family each quarter to review status of identified outcomes, satisfaction with services and supports, delivery of authorized services, significant events and critical incidents related to the participants health and safety. Monitoring will occur every quarter.

a.Team identifies the need of the participant followed by the team matching waivered services to that need that will best meet the need of the participant. Once the waivered service is identified then the case manager assists the family in understanding the service and determining which provider of that waiver would best meet the families need.

b.Parents and identified participant will independently choose who their providers are.

c.The needs of the participant are listed within the care plan and a goal is stated on whom to reach identified goal.

d. Back up plans are reviewed annually to ensure continued effectiveness and to determine if identified individuals are still appropriate to respond when and if needed. If backup plan is utilized the participants team will review how it was used and if it was effective. If it is determined to not be effective team will develop a more effective plan at that time.

e. if there is a non-waiver service listed within the care plan the case manager will monitor and assist with access issues and document them within the care plan.

Follow up is completed monthly with the family by the case manager to ensure the plan is meeting the needs of the participant and to identify any additional problems. If at this time the case manager and family determine a problem the team is pulled together as soon as possible- to develop an alternative plan to address the problem.

All care plans are sent to the state to be reviewed - any problems are communicated by the case manager and through the care plan to the state to be monitored and looked at to identify problems or need for changes within the program.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsï?½ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of service plans with identified personal goals. N: Number of service plans with identified personal goals. D: total number of service plans.

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

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all waiver participants that have a Service Plan addressing the individual needs of the child, as indicated by the team, within 10 working days of

family being assigned to waiver. N: number of service plans that address the individual needs of the child, within ten working days of family being assigned to waiver. D: Total number of waiver participants.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
Number and percent of all waiver participants that have completed an Emergency Back-up Plan as part of the service plan to address health and safety issues, by end of first quarter enrolled. N: number of waiver participants with a completed Emergency Back-up plan as part of the service plan by end of first quarter enrolled. D: total number of waiver participants.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of all participants whose service plans were updated when warranted by changes in the participants needs. N: number of all participants whose service plans were updated when warranted by changes in the participants needs. D total number of participants with changing needs.

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all Service Plans that are updated or revised annually. N: number of service plans updated or revised annually. D: total number of service plans.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
 # and % of participants receiving waiver services as specified on the service plan to include the type, scope, amount, duration and frequency as verified by claims data review. N: number of waiver participants receiving waiver services as specified on the service plan to include the type, scope, amount, duration and frequency as verified by claims data review. D:total number of waiver participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants given a choice of waiver services and providers. N: total number of waiver participants given a choice of waiver services and providers. D: total number of waiver participants.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants that indicated on the yearly survey that they were given explanation of waiver services in the form of a brochure. N: Number of waiver participants that indicated on the yearly survey that they were given explanation of waiver services in the form of a brochure. D: Total number of waiver participants who returned the yearly survey.

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information

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

It is the responsibility of State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance or amending the contract. Documentation is maintained by the State that describes the remediation efforts.
Data is obtained by Central Administrator reviewing service plans. Any individual problems discovered are reviewed with the Central Office Administrator and the Director of Managed Care and Children's Services to determine if there is a systemic problem that requires more holistic solutions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants will have the opportunity to recruit, hire, train, supervise and schedule in-home support workers. Within the guidelines, the participant has the flexibility to determine wages and benefits (i.e. must offer at least minimum wage, follow state and federal withholding requirements and include workers compensation benefit.) Participants determine the vendors/providers from whom they will purchase services and supports. They will also negotiate the cost. Participants will have the opportunity to determine their priorities as a family within the waiver budget limitations. Program Management or Case Manager and Fiscal Agent staff will support participants as they self direct. Information regarding risk and responsibility involved in self direction, recommendations for hiring and supervising employees and considerations when selecting a vendor is provided in writing for participants and the material is reviewed with them. Guidance regarding key decisions and assistance in prioritizing needs will also be offered.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

◉ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Program Management or Case Manager and Fiscal Agent staff will support participants as they self direct. Information regarding risk and responsibility involved in self direction, recommendations for hiring and supervising employees and considerations when selecting a vendor is provided in writing for participants and the material is reviewed with them. The material is contained in a manual developed in collaboration with the North Dakota Center for Persons with Disabilities. The manual reviews the responsibility involved in self-direction. This information will be reviewed with families prior to enrollment in the waiver. Guidance regarding key decisions and assistance in prioritizing needs will also be offered.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
In-Home Supports	☒	☒
Institutional Respite	☐	☒
Transportation	☐	☒
Individual and Family Counseling	☐	☒
Environmental Modification	☐	☒
Dietary Supplements	☐	☒
Equipment and Supplies	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Contract agency. The FMS is procured by applying the North Dakota policies for the procurement process.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Contract indicates monthly fee per enrolled consumer

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Complete Criminal Background Checks and check North Dakota Child Abuse and Neglect Central Registry.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The performance of the Fiscal Agent is reviewed by the Program Manager or Case Manager with the family during a quarterly meeting, any concerns are documented in the Quality Enhancement Review document that is forwarded to the Regional Program Administrator and/or Central Office staff, if the issue cannot be resolved by the Program Manager or Case Manager and family. The family's satisfaction with services is also measured annually through the Systems Indicator Survey. Data from the Systems Indicators is analyzed across regions and types of supports authorized. Central Office staff has frequent (at least every quarter) conference calls with the contracted Fiscal Agent to review issues identified through data analysis of Quality Enhancement Reviews and System Indicators. The authorization process prevents over billing by the Fiscal Agent as the MMIS has edits the prohibits payments in excess of authorized budget limits. Central Office staff monitor monthly budget program spenddown reports generated through MMIS and monthly contract billings for Fiscal Agent services. As outlined in the contract with the North Dakota Department of Human Services, the Fiscal Agent also has agreed to have an independent audit conducted and will share the results.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Program Management or Case Management	☒
In-Home Supports	☒
Institutional Respite	☐
Transportation	☐
Individual and Family Counseling	☐
Environmental Modification	☐
Dietary Supplements	☐
Equipment and Supplies	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The Regional Program Manager will review the ramifications of voluntary termination, including possible impact on Medicaid and health and safety issues for the eligible consumer. Other support options including Medicaid State Plan services, other waivers, or nursing facilities placement will be explored. The Regional Program Manager will assist the family in transition activities.

Families are informed they must self-direct services at each quarterly meeting, at the time of application and at renewal of enrollment determination.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the roles and responsibilities identified in the Case Plan are not carried out and it is directly impacting the health and safety of the eligible consumer, the Regional Program Manager or Central Office Program Manager will notify the family that services are being terminated and review their right to appeal the termination of services offered through this waiver. Other support options including Medicaid State Plan services, other waivers or nursing facilities placement will be explored. The Regional Program Manager or Central Office Program Manager will assist the family in transition activities. A ten-day notice is given to a participant when involuntary termination is required.

Policy of Termination/Denial of services 585-05-40 is discussed with family upon enrollment and reminded as they complete the Authorization of Services as to reference of staying within waiver limits.
Central Program Manager also discussed this with families while they are completing the application of services and what participant directed means in regard to this waiver.

During the ten days prior to the termination date of services, all services would continue as approved. If family decides to appeal the decision, then they may continue with services but if the appeal is not decided in their favor the cost of services provided during this time would have to be repaid.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		25
Year 2		25
Year 3		50
Year 4		50
Year 5		70

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Providers are licensed through the ND Department of Health & Human Services to provide Family Support Services.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☒ **Other**

Specify:

May elect through co-employer to select different staff to work in their home.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individualized budget is developed by the Case Manager after reviewing with the family the specific support needs of the eligible consumer, family stress factors, generic and informal resources available to support the family, the need for specially trained caregivers, and risk of unwanted out-of-home placement. Individualized budgets identify the funds that will be available for each budget line item. The hourly amount for in-home support is standardized based on legislative appropriation. Transportation reimbursement will be projected based on state guidelines. The amount authorized for other self-directed supports will be negotiated based on anticipated costs. The maximum annual amount available per family is capped at $25,300. Families will sign all individualized authorizations to indicate their approval and acknowledge their right to appeal. All individualized authorizations are also reviewed by Regional Program Administrators and must be approved through the Department of Health & Human Services Medical Section before services can begin to assure consistency. All authorizations are reviewed after the quarter to audit the authorization back to the actual amount of funds utilized. This information is then considered as the next authorization is developed. Procedures outlined in this waiver will be available on the Department of Human Services website and a brochure regarding the waiver will also be available for families.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Families will sign all individualized authorizations to indicate their approval of the projected budget and acknowledge their right to appeal. If during the authorization period it becomes necessary to transfer funds from one budget line item to another or if additional funds are needed, the family will request a meeting with their Program Manager or Case Manager to re-negotiate their budget.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (◉) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- (○) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Fiscal Agent contracted has developed an on-line budget balance sheet that indicates total budget, expenditures and remaining funds. This information is available to families and Regional Program Managers. If families request, a copy of the balance sheet report is mailed to them monthly or as requested. Families may also call the Fiscal Agent for updated information.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the

description are available to CMS upon request through the operating or Medicaid agency.

The contracted entity for Level of Care determinations will notify the Central Office Administrator and the consumer's parent or guardian in writing if the child did not meet the Level of Care criteria and what their rights are to request a fair hearing. The consumer's parent or guardian will be notified in writing of the results of the Level of Need determination and what their rights are to request a fair hearing by the Central Office Administrator. Regional Program Managers will notify the consumer's parent or guardian in writing if services are reduced or terminated and of their choice of home and community-based services as an alternative to institutional care. Program Managers or Case Manager will also be available to discuss issues by phone or in person, in addition to written communications. Notices of adverse action are kept at the department and a copy is sent to the case manager to be filed in participant file. The information to request a fair hearing is printed on the bottom of the authorization form and a copy of that authorization is given to the family quarterly.

Notice of termination must be given to the family if: services are negatively affecting health and safety of participant, when a waiver service has not been utilized within a quarter or when eligibility criteria is no longer met.

The following information is given to the family quarterly at a minimum when they sign the authorization per quarter. Right to Appeal a Denial or Termination: Your need for Self-Directed Supports has been reviewed based on the following criteria: 1) Level of Care; 2) the score on Level of Need completed by your child's Primary Care Professional; 3) need for a specially trained caregiver; 4) need for medically related equipment & supplies, transportation, environmental modifications, dietary supplements, and individual/family counseling not otherwise available; and 5) risk of out of home placement. The above criteria are outlined in North Dakota's Home and Community Based Services - Children with Medically Fragile Needs waiver. If you disagree with the proposed Individual Budget, you may request a hearing before the North Dakota Department of Human Services. 42 CFR (Code of Federal Regulations) Subpart E provides an opportunity for a fair hearing to any person if the State agency takes action to suspend, terminate or reduce services of Medicaid eligibility or covered services. Please contact your Program Manager for instructions on how to request a hearing. You must request a hearing in writing within 30 days of the date of this notice. Hearing requests must be forwarded to: Appeals Supervisor, North Dakota Department of Health & Human Services, 600 E. Blvd. Ave-Dept. 325, Bismarck, ND 58505-0250. You may represent yourself at the hearing or you may have an attorney, relative, friend or any other person assist you. If you request a hearing before the date of action, we will not terminate or reduce services until a decision is rendered after the hearing, or you withdraw the request for a hearing, you fail to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. You are advised, however, that if the hearing decision by the Department of Health & Human Services is not in your favor, the total additional amount paid with Medicaid funds on your behalf may be considered an overpayment subject to recovery.

Families will be given a questionnaire annually to allow them to evaluate their case manager and to voice their personal view of the overall quality of the program.

If family is not given the choice of a provider or service, the Department will send a notice to the family and case manager informing them of their right to a choice and offer the family the choice to change providers to one of their choices.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events that must be reported include: An abused child which means an individual under the age of eighteen years who is suffering from serious physical harm or traumatic abuse caused by other than accidental means by a person responsible for the child's welfare, or who is suffering from or was subjected to any act in violation of sections 12.1-20-01 through 12.1-20-07 in state century code.

A child who is harmed which means negative changes in a child's health which occur when a person responsible for the child's welfare: Inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or commits, allows to be committed, or conspires to commit, against the child, a sex offense as defined in state century code chapter 12.1-20. A person responsible for the child's welfare means the child's parent, guardian, or foster parent; an employee of a public or private school or nonresidential child care facility; an employee of a public or private residential home, institution, or agency; or a person responsible for the child's welfare in a residential setting.

The individuals that must report critical events include: Any physician, nurse, dentist, optometrist, medical examiner or coroner, or any other medical or mental health professional, religious practitioner of the healing arts, school teacher or administrator, school counselor, addiction counselor, social worker, day care center or any other child care worker, police or law enforcement officer, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the Department of Health & Human Services or its designee, if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser. Any person having reasonable cause to suspect that a child is abused or neglected or has died as a result of abuse or neglect, may report such circumstances to the department.

In-Home Support employees hired by the family will be required to sign an employment agreement, after reviewing information on how to identify, handle and report, stating they will report all suspected abuse or neglect to the county social service board.
However institutional respite counselors and others are held accountable within their agencies/personal license to do the same reporting.

All persons mandated or permitted to report cases of known or suspected child abuse or neglect shall immediately cause oral or written reports to be made to the department or the department's designee. Oral reports must be followed by written reports within forty-eight hours if so requested by the department or the department's designee. A requested written report must include information specifically sought by the department if the reporter possesses or has reasonable access to that information. Reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under this chapter in state century code.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Through a Family Support Grant from the Administration on Developmental Disabilities, a handbook for families was developed through the North Dakota Center for Persons with Disabilities. The handbook addresses many issues related to self directing supports. It contains a specific section regarding reporting of abuse, neglect and exploitation. This section of the handbook would be shared with the families when they consider entering the waiver and with their employees when hired. The family also signs a Participant Agreement that outlines the requirements to report to Child Protective Services any suspected abuse, neglect or exploitation regarding a child 3-18 years of age. Program Management or Case Manager provides follow-up through the quality review process.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Child Protective Services within the Department of Health & Human Services and its designees receive all reports of abuse, neglect or exploitation of a child. An assigned case worker will then review any and all material pertaining to the report along with personal interviews with identified individuals having any information regarding allegations. This information is given to an intra-disciplinary team of professionals who review and determine if additional services are needed. The whole process is required to begin within 24 hours of receiving the initial report as per outlined in the established state guidelines. The Central Office Administrator will follow-up with Child Protective Services regarding all reported incidents concerning status of child and resolution of investigation. The Case plan and individual budget will be modified as needed.

Communication/ reports between the Department and CPS are shared as requested. As of this date there have not been any abuse and neglect reporting to CPS.
The Child Protective Services within the Department of Health & Human Services and its designees receive all reports of abuse, neglect or exploitation of a child. An assigned case worker will then review any and all material pertaining to the report along with personal interviews with identified individuals including Case Manager's having any information regarding allegations. This information is given to an intra-disciplinary team of professionals who review and determine if additional services are needed. The whole process is required to begin within 24 hours of receiving the initial report as per outlined in the established state guidelines. The Central Office Administrator will follow-up with Child Protective Services regarding all reported incidents concerning status of child and resolution of investigation. The Service Plan will be modified to meet the new needs of child/ family.

The Child Protection Social Worker completing the assessment of a report of suspected child abuse or neglect shall provide notification of the case decision to the subject of the report. This notification shall be made in person. When the case decision is “Services required”, the notification to the subject shall be made face-to-face. If a face-to-face notification cannot be done, the reason needs to be documented. When the case decision is “No Services Required”, the notification may be made either face-to- face or by telephone. Out of respect for the families involved in the assessments process, the report needs to be completed as soon as possible and notification be made to families of the decision. There is not a specific time frame established.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

North Dakota Department of Health & Human Services or its designees review reports as they are received, to discern trends and identify system remediation. Assigned Case Manager will review individual reports/ address reports and needs through the quality enhancement review process quarterly. Currently the ability for individuals managing this waiver to obtain access to the data base of incidents of Child Protective Services reports is being discussed within the Department of Health & Human Services.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is part of the definition of abuse. Therefore, Program Managers are also responsible to report the use of restraints or seclusion as a part of the monitoring process to assure health, welfare and safety.

Unauthorized restraints are required to be reported as suspected abuse, neglect or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10 and DDD-PI-006.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is part of the definition of abuse. Therefore, Program Managers or Case Manager are also responsible to report the use of restrictive intervention as a part of the monitoring process to assure health, welfare and safety.

Unauthorized restraints are required to be reported as suspected abuse, neglect or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10 and DDD-PI-006.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

For the children involved in the Medically Fragile program the case manager is required to conduct home visits quarterly - if they observe seclusion then the team will discuss this and assist the family in positive ways of allowing the child not to be secluded. Also, a report of Abuse and Neglect would be filed with the county designated to investigate abuse and neglect and it would be their job to determine extend of seclusion and the need for further interventions.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

If a hospital is accredited the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health & Human Services, Health Facilities section.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

North Dakota Department of Health & Human Services is responsible for oversight of Basic Care Facilities and of Hospital swing bed facilities. ND Admin Code 33-07-01.1-05, 33-07-01.1-04 and 33-07-01.1-07

If the hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Health Facilities Section has certification responsibility. Each hospital is licensed by the Department of Health & Human Services, Health Facilities section.

Department of Health & Human Services can monitor at any time they choose. 33-07-01.1-05. Continuing surveillance. At any time, the department may evaluate a hospital's compliance with these licensure requirements through an announced or unannounced onsite review scheduled at the discretion of the department.
Individuals may also inform the Department of Health & Human Services of any concerns of care by contacting them directly: How To Report a Concern Department: Department of Health & Human Services process for gathering information. 33-07-01.1-04. Access by the department. Upon presenting identification to the hospital's chief executive officer or designee, authorized agents of the department shall have access to the hospital to determine compliance with licensure requirements. Such access includes: 1. Entry to all hospital premises. 2. Inspection and examination of all of the hospital's records and documents as required by this chapter. 3. Interviewing of any hospital staff, medical staff, or members of the governing body with their consent. 4. Examination of any patient and interview of any patient or the person with legal authority to act on behalf of the patient if this person is available at the facility at the time of the visit, with his or her consent.
The Department of Health & Human Services also agrees to “Plans of Correction” to improve quality of care. 33-07-01.1-07. Plans of Correction. 1. Hospitals shall submit to the department plans of correction addressing the areas of noncompliance with the licensure requirements in this chapter. 2. Plans of correction are required within ten calendar days of receipt of the deficiency statement and are subject to acceptance, acceptance with revisions, or rejection by the department. 3. The department may require a directed plan of correction. A directed plan of correction is a plan of correction, submitted by a hospital in response to cited deficiencies, which has been developed in coordination with the department and has been accepted by the department. 4. Plans of correction must be completed within sixty days of the survey completion date, unless an alternative schedule of correction has been approved by the department.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

◉ **Not applicable.** *(do not complete the remaining items)*

○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

Do not complete the rest of this section

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
Number and percent of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. D: All reports that are substantiated for waiver service providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Abuse and Neglect reports

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of all waiver participants legal caregiver who have signed service plan stating they have received information about how to identify,report abuse/neglect/exploitation incidents of children.N:# of legal caregivers who have signed the service plan stating they have received information on how to identify,report abuse/neglect/exploitation incidents of child D:total number of service plans

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of identified unexplained deaths happening and follow-up addressing and seeking to prevent has occurred for waiver participants. N: total number of identified unexplained deaths where follow-up addressing and seeking to prevent has occurred for waiver participants. D: total number of waiver participant's unexplained deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management report

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all medication errors that occurred by In-Home Support staff will be reported to case manager quarterly. N: number of medication errors reported to case manager quarterly. D: total number of medication errors by In-Home Support staff as answered on returned surveys.

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
 # and percentage of instances of abuse, neglect, exploitation and unexplained deaths where proper follow-up was completed within required timelines. N:number of instances of abuse, neglect, exploitation and unexplained deaths where proper follow-up was completed within required timelines D:total number of instances of abuse, neglect, exploitation and unexplained deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
tracking system and web based management system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:

 # and % of reports where abuse,neglect,exploitation,unexplained death are substantiated,follow-up is completed for waiver providers.N:# of substantiated reports where abuse,neglect,exploitation,unexplained death are substantiated,follow-up is completed for waiver providers D:Total # of substaniated reports involving abuse,neglect,exploitation,unexplained death for waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management report

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incidents where root cause was identified. N: Number of critical incidents where root cause was identified. D: total number of critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
incident management reports

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

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident trends where systemic interventions were implemented. N: Number of critical incident trends where systemic interventions were implemented. D: total number of critical incidents trends.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management reports

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of reported complaints regarding restraints and seclusion that were substantiated through investigation, where follow-up is completed as required. N: Number of restraint and seclusion complaints that are substantiated through investigation, where follow-up is completed as required. D: Total number of substantiated restraint and seclusion complaints reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management Reports

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participant that have indicated during quarterly case management visits that no incident of unauthorized use of restrictive techniques per waiver definition have occurred. N: number of waiver participants that have indicated no restrictive techniques have been used. D: total number of waiver participants.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of incidents where restrictive interventions were used and proper policies and procedures were followed. N = Number of incidents where restrictive interventions were used and proper policies and procedures were followed. D = Total number of incidents where restrictive interventions were used.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Management Reports and restriction page within service plans.

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants who have a yearly Level of Need score, established by a physician. N: Number of participants that receive a yearly Level of Need score, established by a physician.. D: total number of waiver participants.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Data is obtained by Central Administrator concerning abuse and neglect reports. If individual has been identified as having a substantiated incident, the case manager is notified to reach out to the family and assigned Child Protection worker. Resolution of substantiated incidents could result in continued monitoring, removal of client from residences, referral to law enforcement, termination of providers, etc.

Any individual problems discovered are reviewed with the Central Office Administrator and the Supervisor to determine if there is a systemic problem that requires more holistic solutions. This review process may include contacting the case manager, the Program Administrator for that region, Protection and Advocacy. Once all information is reviewed a correction action will be developed if need has been identified. The corrective action may be a change to policy and procedure, assistance offered to families in the form of training or services.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state

spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Central Program Manager will monitor and identify problem areas by reviewing all performance measures quarterly/ annually. Trends and improvement areas will be identified, and communicated supervisor. Any changes or problems that are noted in the program are reported to the State Medicaid Director by the central program manager as needed or if necessary in person depending on the level of urgency.
Problem areas will have a correction plan developed/ implemented and monitored by the Central Program Manager with assistance from identified areas of expertise. These changes will be monitored and additional changes will be modified until problem area is resolved. Information and improvements are reported to supervisor to be shared.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: ongoing

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

System design changes are monitored by the Program Manager and discussed with the Director of Managed Care and Children's Services in ongoing meetings. The Program Manager keeps track of identified problems, the system change to address problems, and if the system change resolved the issue. If no resolution to the problem occurs, the issue is readdressed by the Program Manager and Director of Managed Care and Children's Services.

Input will be obtained from outside participants when appropriate. These participants might be Program Managers, parents, participants, other supports.

In the Therap system there are edits and alerts set to ensure deadlines and guidelines are utilized within correct time frames. Program Manager will also monitor progress of family plans.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

System Changes and common errors or individual problems that have been identified via the audit process are discussed by Program Manager and Director of Managed Care and Children's Services. Input from DD Program Managers involved in the care of children will be encouraged. Positives and negative issues will be identified. System changes or training will be completed to address problem areas. Since QIS are monitored monthly/ quarterly if problems are identified it is at that time they are evaluated, and a plan of action is developed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Fiscal Agent contracted has developed an on-line balance sheet report that indicates total budget, expenditures and remaining funds. This information is available to families and Program Managers. If families request, a copy of the balance sheet report is mailed to them monthly or as requested. Families may also call the Fiscal Agent for updated information. The authorization process prevents over billing by the fiscal agent as the MMIS has edits that prohibit payments in excess of authorized budget limits. Central office staff monitor monthly budget program spend down reports generated through MMIS and monthly contract billings for fiscal agent services. As outlined in the contract with the North Dakota Department of Health & Human Services, the fiscal agent also has agreed to have an independent audit conducted and will share the results. The state does not require any other provider to complete an independent audit.

In-home Support service as of 01/01/2021 implemented the Electronic Visit Verification (EVV) system requirement. All providers of In-Home Support services are required to participate in the EVV system. If a provider decided not to comply with EVV they service will not be paid for. The fiscal agent Veridian currently provides this service to In-Home supports. The EVV data generate the hours to be billed through the In-home Support authorization. Both the EVV data and payment will be verified through an independent aggregator, Sandata before being submitted to MMIS.

The State agency responsible for conducting the state's financial audit is the Office of the State Auditor. An audit of the State of North Dakota Comprehensive Annual Financial Report is conducted annually by the State Auditor's Office. This audit involves examining on a test basis, evidence supporting the revenues, expenditures and disclosures in the financial statements, assessing the accounting principles used and evaluating the overall financial statement presentation.

An agency audit of the Department of Health & Human Services is performed every two years. This audit is a result of the statutory responsibility of the State Auditor to audit each state agency once every two years and is a report on internal control, on compliance with State and Federal laws, and on efficiency and effectiveness of agency operations.

The State Auditor's Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

Process for assurances of correct billing and not errors are as follows. Claims come in from Fiscal Agent, claims are matched against authorization, EVV verification and approves for payment. Claim is paid. Financial department assures the claim is paid correctly and the money is taken out of designated waiver, and that identified child is within the waiver. Central Program Manager, reviews claims every 6 months to identify problems and corrections needed.

Family and team develop a service plan and authorization form for waiver services to address identified child's needs. The authorization is sent to Fiscal Agent for file and comparison of requested payment. Once a request comes into the fiscal agent for a waivered service it is checked against the authorization to ensure payment is agreed upon. Payment is made, followed by Fiscal Agency billing the MMIS system for reimbursement of payment of waivered service. This request is again compared to the authorization for correct child and amount. Reimbursement is made followed by Financial Department ensuring child is identified to waiver and payment is made correctly out of right department. This information is reported to CMS as scheduled.

In addition the Program Manager ensures the Authorization is followed and that payment for waiver service is completed correctly and that fiscal agent has been paid, within the MMIS system. This occurs quarterly.

Central Program Manager reviews the authorization of service to the Fiscal Agent's balance sheet to ensure correct services are listed and paid out on the balance sheet, every 6 month. Once payment are made against the balance sheet, the payment is compared to what was billed in MMIS for accuracy. The authorization, balance sheet and MMIS billing should all match if an error is determined the Central Program Manager will reach out to the fiscal agent to determine corrective action. This might be in the form of recoupment of funds, training opportunity or claims adjustment. 100% of all claims made by the fiscal agent within MMIS are reviewed by the Central Program Manager. When inappropriate claims are identified and needing to be recouped/removed from claims. The Central Program Manager will issue an adjustment within the MMIS system and funds will be recouped from future payment made to fiscal agent. Inappropriate claims are recouped from the provider by the fiscal agent in partnership with the state. The recoupments of FFP is correct and reported within the next 64 report filed by the state. There are no claims from the providers within MMIS, all payments to providers are done by the fiscal agent followed by fiscal agent creating a claim in MMIS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
Number and percent of all MMIS claims for Children with Medically Fragile Needs waiver participant's services that match authorizations. N: Number of MMIS claims for Children with Medically Fragile Needs waiver participant's services that match authorizations. D: Total number of claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all claims for the Medically Fragile Waiver reviewed and matched against authorizations for correct codes and paid for in accordance to approved service. N: number of claims for the Medically Fragile Waiver reviewed and matched against authorizations for correct codes and paid for in accordance to approved service. D: total number of reviewed claims

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *every 6 months*	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *every 6 months*

Performance Measure:
Number and percent of all claims for the MFW reviewed are in accordance with reimbursement methodology as set within approved waiver and only for services rendered. N: Number of all claims for the MFW reviewed in accordance with reimbursement methodology as set within approved waiver and only for services rendered. D: total number of MFW reviewed claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
review of claims within MMIS

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of payment rates that are consistent with the rate methodology in the approved waiver throughout the five year waiver cycle. N: number of payment rates that are consistent with the rate methodology in the approved waiver throughout the five year waiver cycle. D: total number of payment rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:

MMIS

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

b. Methods for Remediation/Fixing Individual Problems

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

The Central Administrator is tasked with reviewing data obtained from reviewing claims/ authorizations. It is also the responsibility of State staff to address individual problems when they are identified. These problems may be resolved through various methods, to include but are not limited to 1-providing one-on-one technical assistance, 2-amending the contract or 3- changes made to policy and procedures. Documentation of corrective actions are maintained by the State. Any individual problems discovered are reviewed with the Central Office Administrator and the Director of Managed Care and Children's Services to determine if there is a broader systemic problem that would require the state to make changes across all providers of identified service.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Program Managers or Case Manager will develop individual budget authorizations based on hours of support needed, based on the individual service plan. The initial maximum hourly rate was determined based from nursing facility rates, MMIS cost utilization data and the 372 report year 2019 and existing Family Support Services programs. The maximum allowed in the other budget categories was based from nursing facility rates, MMIS cost utilization data and information from the existing Family Subsidy program. The rates in the above areas will be adjusted based on allowed increases approved through the legislative budget process.

Families can set the rate for their In-home support staff within the limits set by the state (must be min wage or more and must remain within personal budget of the 18966.00 per year of waivered services) Rates are made available to families through their Case Manager while discussing the development of authorization of services or any other time needed. Program managers or Case Manager meet with family, followed by authorization being looked over by Program managers supervisor in comparison to service plan followed by Center program manager looking at hours/needs and available funding to family.

Prior to any public comment posting the rates for the waiver are reviewed for renewals and amendments. The State reviews the service cost to the actual utilized cost of services and set rates of comparable services to ensure costs are within the range to provide the services. The "entity" within the state responsible for setting the rates is made up of a team the state fiscal accounting liaison, department chief financial officer, central program manager, supervisor of central program manager, and ND legislators.

Public comments are solicited concerning rate changes during the public notice of the waiver being submitted, at that time they may make comments by email/ calling or in writing to the department. All comments are public and shared upon request. Families and Advocacy groups are encouraged to give testimony during Legislation Budget hearings and interim Human Service Committee Hearings. Refer to Main Section 6-1 for information concerning public comments.

Rates were reviewed and where appropriate rebased in 2021 prior to public comment requests posting. The services that were rebased in 2021 are Case Management, Dietary Supplements, Environmental Modifications, Equipment and Supplies, In-Home Support and Transportation. Institutional Respite and Individual and Family Counseling were reviewed during this time but determined to remain appropriate. Rates were rebased by comparing the last waiver year estimates to actually paid claims during the past year. When there were no actual costs to be determined the fee service rates within the department were compared. Adjustments to the estimated rates were then determined based on this review. The waiver follows the departments example of having consistent rates across the state.

Transportation: The rate is based on prior authorization of mileage and transportation related costs such as lodging and meals. The state reimbursement guidelines regarding transportation reimbursement are followed as they are for Medicaid State Plan transportation reimbursement. These reimbursement rates of lodging and meals were initially established by the Department based on historical, reasonable, and customary costs. They may be inflated due to legislative increases.

Dietary supplements: costs are based on the actual cost of the supplements approved.

Individual and Family Counseling: based on cost of service established at the human service centers.

In-home Support: Family's negotiation rate of individuals they hire to work within their homes based on staying within min. wage and budget of allotted money. These wages are then approved through the authorization process within the care planning.

Equipment and Supplies: costs are based on the actual cost of the modification or the cost of the equipment. Environmental Modifications costs must be the lower of two bids. Cost proposals for Environmental Modifications and Equipment and Supplies are reviewed to assure that preliminary costs do not exceed the individual budget amount.

Institutional Respite: Family's negotiation rate of stay with institution of their choice and must remain under maximum cap of budget ($18,966.00)

Case management: based on the rate within the human service center rate setting of case management services.

Program manager or Case Manager is responsible to ensure family is utilizing allotted money in areas identified on

service plan as a needed service to enhance independence of waiver individual.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The Fiscal Agent is required to complete requests for payments on electronic claims that are processed through the Medicaid Management Information System. These documents are electronically completed.
All payments for waiver services go through the fiscal agent Veridian for payment – no provider bills directly to Medicaid.

The flow of billing is as follows:
Identified individual and primary caregiver enrolls within the contracted fiscal agent Veridian. Once enrolled the approved authorization of waiver services is sent to Veridian and a balance sheet is created for approved services and approved funds. Once service is rendered the primary caregiver completes a Payment Request Form stating date of service/description of service/ service code and amount to be paid. Invoice is also attached to this form. This is sent Veridian who compares the Payment Request form against the authorization on record and against the balance sheet. If all is correct a payment is generated to the identified provider. If any step is determined to have errors the payment is suspended until corrections are made. Veridian then creates a claim within MMIS for reimbursement of payout. The claim looks to see if the identified individual is enrolled in Medicaid and is in the appropriate benefit plan for the waiver, checks against the service authorization that is within MMIS for the approved service and if funds are available. Once all checks are confirmed the claim will pay. If any check if determined to be wrong the claim will deny. Remittances are generated with information on paid and denied claims for Veridian to review.
If payment request is for In-Home Support Services, then EVV becomes part of the checks to ensure service is rendered and the six EVV components were verified. The In-Home Support claim requests from Veridian for MMIS payment will be verified through Sandata's aggregator before going to MMIS for payment.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Medicaid payment system will only pay claims if the individual is an approved Medicaid recipient; has a valid Level of Care, meets the Level of Need and has an Individual Service Plan that authorizes the waiver services; and has an approved individualized authorization (budget). The claim will deny if the individual is not Medicaid eligible or does not have an approved Individual Service Plan or authorization. The claim will suspend if the remaining approved budget amount is less than the billed amount.
The claim for In-home Support services will deny if the claim does not meet EVV 6 point requirements.
Quarterly the Program Manager or Case Manager will review with the consumer or their representative the number of services utilized and adjust the budget within the individualized authorization back to actual. Payments that are in excess of what is authorized or are unallowable are recouped from the Fiscal Agent.
Fiscal agent compares request for reimbursement to Authorization. If the request is not on the authorization it is not paid. If request is over what has been authorized, then the payment is only for amount approved. Online access to payments is available for view from central program manager, legal caregiver/individual and program manager to double check on payment or errors.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The same Fiscal Agent (FA) will be used as is used for other self-directed waivers. The contracted fiscal agent is Veridian. All supports included in this waiver will be paid through the Fiscal Agent. The FA will assure that payments do not exceed the budget within the individualized authorization, develop and maintain employee files, pay the employees the families have hired, pay the vendors selected by the families, and withhold and report all required state and federal taxes and benefits.

Quarterly, the Regional Program Manager will review with the consumer or their representative the amount of services utilized and adjust the budget within the individualized authorization back to actual. Payments that are in excess of what is authorized or are unallowable are recouped from the Fiscal Agent.

Monthly contract billings for Fiscal Agent services are reviewed to assure they are only billing for individuals approved to receive waiver services.

The Medicaid Agency randomly reviews employee's files and withholding records to assure the scope of the fiscal agent contract is being implemented.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of***

the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have

free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) **No. The state does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6228.47	29560.00	35788.47	116377.00	120789.00	237166.00	201377.53
2	6293.07	29856.00	36149.07	117541.00	121997.00	239538.00	203388.93
3	6487.95	30752.00	37239.95	121067.00	125657.00	246724.00	209484.05
4	6684.17	31674.00	38358.17	124699.00	129427.00	254126.00	215767.83
5	4544.23	32307.48	36851.71	127192.98	132015.54	259208.52	222356.81

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	25	25
Year 2	25	25
Year 3	50	50
Year 4	50	50
Year 5	75	75

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Based on the time period of June 1.2022 through May 31.2023 the average number of days on the waiver was determined to be 213. This ALOS was determined from the 2023 372 report generated from MMIS.

It was determined this was a realistic estimate of time on the waiver of 245.5 with new families coming on and some leaving because of moving, no longer having a waiver need or screening off.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Costs are based on actual expenditures from the CMS 372 report that was approved for year 06/01/2017 to 05/31/2018 and comparable state services. For the first two year of the waiver there was figured a 1% increase yearly followed by an anticipated 2% thereafter. It has been estimated the anticipated number of waiver users to be 25 individuals.

The sources used to develop the estimates of users and units was the combination of various data sources to including estimated spenddowns of DHS budget for 2019-2021, CMS 372 reports for year 2019 reporting, and the estimated legislation appropriation for providers.

In addition the state looked at the longevity of individuals on the waiver and their usage history. It was noted units used historically for In-Home Support and equipment and supplies were consistent across quarters and it was determined it was highly likely the usage would continue this pattern across the years. The years reviewed to determine longevity were waiver years 3 -5 of current approved waiver and the service authorizations within MMIS

The 2017-2018 372 report was used since that was the most recent approved 372 at the time of building budget. The state determined with looking at trends and data from actual costs of service and department estimated budgets along with the small number of users for the program and the length of time users remained on the waiver, one year was an acceptable picture of units and users. The state has estimated the legislation appropriation to be a 1% increase for year 1 and 2 with 2% increase for following years. This is based off the department's budget building process for legislation session 2021.

Amendment effective 10/01/2023
Years 3 -5 increased by 25 individuals (legislation approval) for a total of 50 individuals.
For year 3 Legislation provider a 3% cost increase and it has been determined to follow this trend for year 4 and 5 of the waiver.
The sources used to develop the estimates of users and units was the combination of reviewed spenddowns of DHS budget for 2019-2021, CMS 372 reports for year 2019 reporting, and the estimated legislation appropriation for providers.
In addition, the state looked at the longevity of individuals on the waiver and their usage history. It was noted units used historically for In-Home Support and equipment and supplies were consistent across quarters and it was determined it was highly likely the usage would continue this pattern across the years. The years reviewed to determine longevity were waiver years 3 -5 of approved waiver ND.0568.R02.02 and the service authorizations within MMIS during the past year.
The 2017-2018 372 report was used since that was the most recent approved 372 at the time of building budget. The state determined with looking at trends and data from actual costs of service and department estimated budgets along with the small number of users for the program and the length of time users remained on the waiver, one year was an acceptable picture of units and users. The state legislation appropriation of 3% increase for years 3 – 4 of waiver was applied. This is based off the department's budget building process for legislation session 2021, and 2023 legislation session. 2025 legislation session provided a 2% increase therefore year five was adjusted to this increase.
the number of users was doubled from original estimate since is was and additional 25 slots being added and state determined individuals would have similar needs to the current 25 occupied slots.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The 2017-2018 372 report was used since that was the most recent approved 372 at the time of building budget. The state determined with looking at trends, and data from actual costs of service and department estimated budgets along with the small number of users for the program and the length of time users remained on the waiver one year was an acceptable picture of units and uses. The state has estimated the legislation appropriation to be a 1% increase for year 1 and 2 with 2% increase for following years. This is based off the department's budget building process for legislation session 2021.
there are no dual eligible participants within the sample population there was no amount to be accounted or removed for the service of prescribed drugs purchased through Medicare Part D.

Factor D' is less than Factor G' is the state utilized actual costs of D' from paid claims whereas Factor G' is based on nursing home rates from departments fiscal send-down reports. Nursing home costs may be higher due to the nursing home covering more nursing cares and other needs that would normally be covered by a parent when individual is living in the parent home.

Amendment effective 10/01/2023
With the completion of legislation session on April 30, 2023, the 2023 legislation awarded a 3% increase to services for the remaining 3 years.
Amendment effective 11/01/2025
2025 legislation session provided a 2% increase therefore year five was adjusted to this increase.

there remains no dual eligible participants within the sample population there was no amount to be accounted or removed for the service of prescribed drugs purchased through Medicare Part D.

Factor D' is less than Factor G' is the state utilized actual costs of D' from paid claims whereas Factor G' is based on nursing home rates from departments fiscal send-down reports. Nursing home costs may be higher due to the nursing home covering more nursing cares and other needs that would normally be covered by a parent when individual is living in the parent home.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G was determined by using costs determined for nursing home care for children within the Children's' Hospice waiver as this would be the same population within a nursing home for medically fragile children. This data was generated from the departments spend down reports at that time. This waiver determined year 3 factor G total within the Children's Hospice waiver was accurate for first year of the Medically Fragile waiver since this year lined up to be the current year. Data of year three of the Children's Hospice waiver were taken from the department's spend down sheets for year 2018.Each year was then increased by 1% for year one and two followed by 2% increase the remaining years, as these are projections of what Legislation will provide to providers after 2021 legislation session.

Amendment effective 10/01/2023
Years 3-5 increased by 3% that was provided by 2023 legislation session. This was done by increasing amounts from year 2 by 3% and applying same process to year 4 and5
Amendment effective 11/01/2025
2025 legislation session provided a 2% increase therefore year five was adjusted to this increase.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on the non-Nursing Home costs which are of a higher medical focus to include costs that if the child is home, would not occur – ie. Medical appointments and monitoring of appointments. These costs are covered by the parent when the child is in the home. Therefore, the cost of being home with medical issues is less than being in a nursing home. It was determined the cost of Children Hospice participants would be the same as Medically Fragile children within a nursing home setting therefore this waiver is utilizing the same costs as year three of the Children's Hospice waiver G' with a determined 1% cost of living for the first two years of waiver followed by 2 % each year thereafter, as these are projections of what Legislation will provide to providers after 2021 legislation session. Data of year three of the Children's hospice waiver were taken from the department's spend down sheets for year 2018. Since there are no dual eligible participants within the sample population there was no amount to be accounted or removed for the service of prescribed drugs purchased through Medicare Part D.

Amendment 10/01/2023
Years 3-5 increased by 3% that was provided by 2023 legislation session. This was done by increasing amounts from year 2 by 3% and applying same process to year 4 and 5.
Amendment effective 11/01/2025
2025 legislation session provided a 2% increase therefore year five was adjusted to this increase.
Since there are no dual eligible participants within the sample population there was no amount to be accounted or removed for the service of prescribed drugs purchased through Medicare Part D.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Institutional Respite	
Program Management or Case Management	
Dietary Supplements	
Environmental Modification	
Equipment and Supplies	
In-Home Supports	
Individual and Family Counseling	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite Total:						5267.08
Institutional Respite	Day	2	14.00	188.11	5267.08	
Program Management or Case Management Total:						12360.00
Program Management or Case Management	15 minutes	25	24.00	20.60	12360.00	
Dietary Supplements Total:						2204.60
Dietary Supplements	Item	2	365.00	3.02	2204.60	
Environmental Modification Total:						8217.36
Environmental Modification	Item	2	1.00	4108.68	8217.36	
Equipment and Supplies Total:						13635.00
Equipment and Supplies	Item	5	1.00	2727.00	13635.00	
In-Home Supports Total:						111335.04
In-Home Supports	15 min	17	1728.00	3.79	111335.04	
Individual and Family Counseling Total:						551.52
Individual and Family Counseling	15 minutes	1	16.00	34.47	551.52	
Transportation Total:						2141.20
Transportation	Trips	2	2.00	535.30	2141.20	
				GRAND TOTAL:		155711.80
				Total Estimated Unduplicated Participants:		25
				Factor D (Divide total by number of participants):		6228.47
				Average Length of Stay on the Waiver:		229

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite Total:						5319.72
Institutional Respite	Days	2	14.00	189.99	5319.72	
Program Management or Case Management Total:						12480.00
Program Management or Case Management	15 minutes	25	24.00	20.80	12480.00	
Dietary Supplements Total:						2226.50
Dietary Supplements	Item	2	365.00	3.05	2226.50	
Environmental Modification Total:						8299.54
Environmental Modification	Item	2	1.00	4149.77	8299.54	
Equipment and Supplies Total:						13771.35
Equipment and Supplies	Item	5	1.00	2754.27	13771.35	
In-Home Supports Total:						112510.08
In-Home Supports	15 min	17	1728.00	3.83	112510.08	
Individual and Family Counseling Total:						556.96
Individual and Family Counseling	15 Minutes	1	16.00	34.81	556.96	
Transportation Total:						2162.60
Transportation	Trips	2	2.00	540.65	2162.60	
				GRAND TOTAL:		157326.75
				Total Estimated Unduplicated Participants:		25
				Factor D (Divide total by number of participants):		6293.07
				Average Length of Stay on the Waiver:		229

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite Total:						10958.64
Institutional Respite	Days	4	14.00	195.69	10958.64	
Program Management or Case Management Total:						25716.00
Program Management or Case Management	15 minutes	50	24.00	21.43	25716.00	
Dietary Supplements Total:						4584.40
Dietary Supplements	Item	4	365.00	3.14	4584.40	
Environmental Modification Total:						17097.04
Environmental Modification	Item	4	1.00	4274.26	17097.04	
Equipment and Supplies Total:						28369.00
Equipment and Supplies	Item	10	1.00	2836.90	28369.00	
In-Home Supports Total:						232070.40
In-Home Supports	15 min	34	1728.00	3.95	232070.40	
Individual and Family Counseling Total:						1147.20
Individual and Family Counseling	15 Minutes	2	16.00	35.85	1147.20	
Transportation Total:						4454.96
Transportation	Trips	4	2.00	556.87	4454.96	
				GRAND TOTAL:		324397.64
				Total Estimated Unduplicated Participants:		50
				Factor D (Divide total by number of participants):		6487.95
				Average Length of Stay on the Waiver:		246

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite Total:						11287.36
Institutional Respite	Days	4	14.00	201.56	11287.36	
Program Management or Case Management Total:						26484.00
Program Management or Case Management	15 minutes	50	24.00	22.07	26484.00	
Dietary Supplements Total:						4715.80
Dietary Supplements	Item	4	365.00	3.23	4715.80	
Environmental Modification Total:						17609.96
Environmental Modification	Item	4	1.00	4402.49	17609.96	
Equipment and Supplies Total:						29220.10
Equipment and Supplies	Item	10	1.00	2922.01	29220.10	
In-Home Supports Total:						239120.64
In-Home Supports	15 min	34	1728.00	4.07	239120.64	
Individual and Family Counseling Total:						1181.76
Individual and Family Counseling	15 minutes	2	16.00	36.93	1181.76	
Transportation Total:						4588.64
Transportation	Trips	4	2.00	573.58	4588.64	

GRAND TOTAL:	334208.26
Total Estimated Unduplicated Participants:	50
Factor D (Divide total by number of participants):	6684.17
Average Length of Stay on the Waiver:	246

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite Total:						**11513.60**
Institutional Respite	Days	4	14.00	205.60	**11513.60**	
Program Management or Case Management Total:						**27012.00**
Program Management or Case Management	15 minutes	50	24.00	22.51	**27012.00**	
Dietary Supplements Total:						**4818.00**
Dietary Supplements	Item	4	365.00	3.30	**4818.00**	
Environmental Modification Total:						**17962.16**
Environmental Modification	Item	4	1.00	4490.54	**17962.16**	
Equipment and Supplies Total:						**29804.50**
Equipment and Supplies	Item	10	1.00	2980.45	**29804.50**	
In-Home Supports Total:						**243820.80**
In-Home Supports	15 min	34	1728.00	4.15	**243820.80**	
Individual and Family Counseling Total:						**1205.44**
Individual and Family Counseling	15 minutes	2	16.00	37.67	**1205.44**	
Transportation Total:						**4680.40**
Transportation	Trips	4	2.00	585.05	**4680.40**	

GRAND TOTAL:	**340816.90**
Total Estimated Unduplicated Participants:	**75**
Factor D (Divide total by number of participants):	**4544.23**
Average Length of Stay on the Waiver:	213