

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

- Minimum age of 18 for waiver services was added.
- Removed nurse management as a separate service, made it a component of attendant care.

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 §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Medicaid Waiver for Home and Community Based Services
- C. **Type of Request: renewal**

Renewal of Waiver Number:

Waiver Number: ND.01.01.00

Application ID: **1506**

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

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

Approved Effective Date: 04/01/07

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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR 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 §1915(a) of the Act and described in Appendix I**
 Waiver(s) authorized under §1915(b) of the Act.

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

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

- §1915(b)(1) (mandated enrollment to managed care)**
 §1915(b)(2) (central broker)
 §1915(b)(3) (employ cost savings to furnish additional services)
 §1915(b)(4) (selective contracting/limit number of providers)
 A program authorized under §1115 of the Act.

Specify the program:

2. Brief Waiver Description

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

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

Goals and Objectives: The goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. In order to successfully meet the mandate, a consumer-centered, affordable delivery

system has been established for delivery of in-home services to the elderly and physically disabled.

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

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

When applicable, other State agencies or other Department of Human Services Divisions have participated in discussions in establishing and maintaining a quality system. They have played a crucial role in the decision making process. Some of the other State agencies and Divisions that have contributed in identifying service needs are: Indian Affairs Commission; Health Department; Minot State University; Protection and Advocacy; ND Department of Human Services Aging Services Division, Developmental Disabilities Division, Division of Mental Health & Substance Abuse, Vocational Rehabilitation, Civil Rights Office, Legal Services Division.

Several non-governmental entities provided input including: AARP, Independent Living Centers, ND Disabilities Consortium, current and potential consumers, family members, and service providers.

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

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

Currently, the only case management entities that provide services are (local) county social service boards. However, other case management agencies or individuals who meet the minimum provider requirements are eligible to provide case management services. QSP enrollment books are available on the Department of Human Services website. Interested parties may also request a copy of the enrollment book directly from the Department of Human Services. Technical assistance is provided upon request.

Organizational Structure:The North Dakota Department of Human Services, Medical Services Division is the operating agency and will administer the Waiver.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

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

No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights

and other procedures to address participant grievances and complaints.

- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management 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 §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 §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 §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 §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit

cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- 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 §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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 Management.** 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 Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
Information for the development of the waiver was obtained from a work group consisting of: Consumers, OAA

service providers, County Social Service Boards, AARP, Protection & Advocacy, Independent Living Centers, Long Term Care Association, ND Disabilities Consortium, Waiver service providers, and Department of Human Services staff. Additional information was obtained through statewide Department of Human Services stakeholder meetings and Aging Services/HCBS State input hearings.

The draft Waiver was forwarded to tribal entities and interested parties prior to the submission of the renewal request to CMS.

- 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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Dakota**

Zip:

Phone: **ext.**

Fax:

E-mail:

- 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.**
Fax:
E-mail:

8. Authorizing Signature

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

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

Signature:
 State Medicaid Director or Designee

Submission Date:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **North Dakota**
Zip:
Phone:
Fax:
E-mail:

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Aged and Disabled Waiver was merged into the TBI Waiver and is now titled the Medicaid Waiver for Home and Community Based Services. The two waivers were merged to simplify the administrative and reporting process.

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: do not complete Item A-2*):

- The Medical Assistance Unit.**

Specify the unit name:

Long Term Care Continuum Unit, Medical Services Division

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

Specify the unit name:

Do not complete item A-2.

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

Specify the 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.*

Appendix A: Waiver Administration and Operation

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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

Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

- 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:

County Social Service Boards perform waiver functions at the local level.

- 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:
Medical Services Division, North Dakota Department of Human Services

Appendix A: Waiver Administration and Operation

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

Counties are reviewed every year, either on –site or via desk audit. Both on-site and desk reviews use the same review guide to evaluate compliance with level of care determinations, response to waiver participant needs, health and welfare, provider qualifications, and financial accountability. On site reviews differ from desk reviews because County staff are unaware of the files that will be chosen prior to the review and include client visits, an exit interview, and the provision of technical assistance as it pertains to the review findings.

Dual Diagnosis Management is monitored by daily reporting via web application, monthly reports from DDM to the Department, input from counties regarding service performance, weekly telephone contact with DDM regarding contract components and input of screening into MMIS assuring timely completion of reviews.

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.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruit providers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 a group 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 waiver target group, check each of the subgroups in the selected target group 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 SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18	64	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>

<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Illness				
<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Additional Criteria for Disabled (other) - The disabled (other) group includes individuals with brain injury, dementia or who are vent dependent.

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

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

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

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

Specify the percentage:

- Other**

Specify:

The cost is limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Department of Human Services. Rates are published once per year. Current rates are available by

contacting the Department of Human Services Rate Setting Administrator. Currently, the highest monthly nursing home rate is \$10,543.

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

A comprehensive assessment will identify the formal and informal service needs of the individual and provider

availability. If the plan of care could not assure the health, welfare, and safety of the individual, services would be denied. The individual would receive appropriate notification of appeal rights.

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

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

- Other safeguard(s)**

Specify:

Case management services will assist the individual to identify other community resources or options. If the comprehensive assessment identifies that the formal and informal service needs of the individual and provider availability are not adequate to assure the health, welfare, and safety of the individual. Services would be terminated. The individual would receive appropriate notification of appeal rights.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	400
Year 2	427
Year 3	454
Year 4 (renewal only)	481
Year 5 (renewal only)	508

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

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

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

Table: B-3-b

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

Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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:

Case managers assess the need for services through a comprehensive assessment. Prior approval is required for the following services; higher level case management, environmental modification, specialized equipment, adult residential care, transitional care and attendant care. Cost proposals for environmental modification, specialized equipment, and adult residential services are reviewed to assure that preliminary costs do not exceed the individual cost limit.

Once eligibility is determined, the applicant must choose an enrolled service provider(s). Entrance into the Waiver occurs, once all eligibility criteria have been met, and the service provider is authorized. With the exception of the services described above case managers authorize Waiver services without prior approval from the Department. The Department currently does not have a waiting list for the Home and Community Based Services Waiver.

In the event projections would reflect a potential waiting list, either due to restricted capacity levels or appropriation shortfalls, the Department will require the case managers to seek prior approval for a Waiver slot. The Department would approve services on a first come/first serve basis once a pre-approval package, reflecting that eligibility criteria has been met, and is forwarded to the State.

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. **State Classification.** The State is a (*select one*):
- §1634 State
 - SSI Criteria State
 - 209(b) State
- 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)

- Low income families with children as provided in §1931 of the Act
- 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 §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §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 §1902(e)(3) of the Act)
- Medically needy

- 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 spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- 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 (*select one*):

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. **Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

- c. **Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

- d. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §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 §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, a family allowance, and an amount for incurred expenses for medical or remedial care.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

section is not visible.

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:

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

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

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

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

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

Specify the entity:

Dual Diagnosis Management

- Other**

Specify:

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

Registered, Licensed Practical, or Licensed Vocational Nurse

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

The level of care instrument used by the State to evaluate and reevaluate whether an individual needs services through the waiver is entitled the Level of Care (LOC) Determination form. The completed document must be

approved by the Dual Diagnosis Management (DDM) to verify that the individual meets nursing facility level of care, as defined in North Dakota Administrative Code (N.D.A.C) 75-02-02-09.

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

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

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

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

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

Specify the other schedule:

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
 - The qualifications are different.**

Specify the qualifications:

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

Case managers are responsible to retain a schedule of when re-evaluations are due. In addition, DDM generates a report to the Department and the appropriate case manager that lists those individuals whose re-evaluations will become due the following quarter.

- 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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Case management entities retain copies of the instrument and approvals/denials of screenings. DDM retains records

that are available to the Department.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State requires the case management entity to obtain signatures of applicants/consumers or legal representatives on the following forms: Explanation of Client Choice SFN 1597, Application for Service SFN 1047, and the Individual Care Plan SFN 1467.

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

- b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Case Management entity maintains the forms.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
When a consumer is unable to independently communicate with a case manager or State reviewer, a family member or community interpreter is present.

The Department has a limited english proficiency implementation plan that provides guidelines and resources.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Care
Statutory Service	Adult Residential Care
Statutory Service	Case Management
Statutory Service	Homemaker
Statutory Service	Respite Care

Statutory Service	Supported Employment
Other Service	Adult Family Foster Care
Other Service	Attendant Care Service
Other Service	Chore
Other Service	Emergency Response
Other Service	Environmental Modification
Other Service	Non-Medical Transportation
Other Service	Specialized Equipment & Supplies
Other Service	Transitional Living

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

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

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

Service Definition (Scope):

Adult Day Care is a community-based service offered within a group setting designed to meet the needs of functionally impaired adults. It is a structured, comprehensive service that provides a variety of social and related support services in a protective setting during a part of a day. Meals provided as part of these services shall not constitute a full, nutritional regimen (3 meals/day).

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

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

--	--

Provider Category	Provider Type Title
Agency	Individuals & Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Individuals & Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

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

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

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Adult Residential Care

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

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

Service Definition (Scope):

A residential program specializing in care of individuals with chronic moderate to severe memory loss or an individual who has a significant emotional, behavioral, or cognitive impairments and needs the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building. The individual requires protective oversight and supervision in a structured environment that is professionally staffed to monitor, evaluate and accommodate an individual's changing needs. It is also a service in which assistance with

ADL's/IADL's, therapeutic, social, and recreational programming is provided. Care must be furnished in a way that fosters the maintenance or improvement in independence of the recipient.

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

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

This service includes 24-hour on-site response staff. Medication administration is allowed at the least costly means permitted by State Law. Non- medical transportation may be provided as a component of this service and is included in the rate. Payment for residential services are not made for room and board, items of comfort or convenience, or the costs of building maintenance, upkeep and improvement. The agency must provide services to at least 5 adults; provide personal cares, therapeutic, social, and recreational programming.

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

Residential settings that serve less than 5 individuals are defined in N.D.C.C. 50-11 as Adult Family Foster Care (AFFC) homes. The needs of individuals residing in AFFC homes are governed under the licensing requirements in N.D.C.C. 50-11 and N.D.A.C. Chapter 75-03-21.

To avoid duplication homemaker, chore, emergency response system, adult day care, adult family foster care, respite, transitional care, attendant care, environmental modification, and non-medical transportation are not allowable service combinations for individuals receiving adult residential services. Non-medical transportation is not allowed because it included in the rate for adult residential services.

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Residential Care

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

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

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of agency status change.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

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

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

Service Definition (Scope):

Case management assists functionally impaired individuals to achieve and maintain independent living in the living arrangement of their choice. The case manager assists individuals to gain access to waiver and other formal/informal services. Case managers assist the client to explore and understand options, make informed choices, solve problems, and provide a link between community resources, qualified service providers, and the client.

Case management requires the completion of a comprehensive assessment of needs, care planning, implementing care plan, monitoring, reassessing, and closure/termination of services.

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

An initial evaluation will be provided to an applicant to determine Waiver eligibility. Thereafter, at a minimum, quarterly contacts are required.

A higher rate may be used for higher-level case management. Higher level case management is limited to cases that require case management participation in care plan meetings with an interdisciplinary team on a regular basis or a case that requires frequent face to face visits to assist care plan development and monitoring. Case managers must get prior approval from the Department of Human Services before they can bill using the higher-level case management rate.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency & Individual

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency & Individual

Provider Qualifications**License (specify):**

ND SW License N.D.C.C. 43-41-01 to 43-41-14; N.D.A.C. 75.5-01 and 75.5-02

Certificate (specify):

Other Standard (specify):

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07, user License for Synergy Software System Data Base for Case Management Assessments. Currently, the cost of acquiring a Synergy Software license is \$830 for the first year and \$530 thereafter.

Provider Qualifications**Entity Responsible for Verification:**

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

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

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

Service Definition (Scope):

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

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

Homemaker service is offered to individuals living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks. If the individual lives with a capable person or provider and the tasks needed to maintain the client's independence are extraordinary homemaker services are available.

The cost of this service is limited up to a maximum of \$195 per month. This amount allows for approximately 11 hours of service per month at the highest provider rate allowed. If a participant has a need for cleaning of an unusual nature chore services would be authorized. This cap may be increased as determined by legislative action. The case manager makes participants aware of the service cap.

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual & Agencies

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

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

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

Provider Qualifications**Entity Responsible for Verification:**

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of provider status change

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

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

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

Service Definition (Scope):

Respite Care is for the purpose of providing temporary relief to the individual's primary care provider from the stresses and demands associated with constant care or emergencies.

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

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

The cost of this service is limited up to a maximum of \$580 per month. The cap allows for approximately 8 hours of in-home respite care per week at the maximum provider rate allowed or 4 days of institutional respite care per month. If multiple clients live in the same home and have the same primary caregiver the respite cap must be divided by the number of client's in the home. The per day cost of institutional or in-home respite care cannot exceed the swing bed rate. This cap may be increased as determined by legislative action.

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:Individual **Provider Type:**

Individual & Agency

Provider Qualifications**License (specify):**

Agency only - N.D.C.C. 23-16, N.D.A.C. 33-07-01, 3307-03.1 N.D.A.C. 33-03-24.1

Certificate (specify):**Other Standard (specify):**

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

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

Provider Qualifications**Entity Responsible for Verification:**

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:Statutory Service **Service:**Supported Employment **Alternate Service Title (if any):**

Supported Employment

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

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

Service Definition (Scope):

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

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

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

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) Federal financial participation is not claimed for incentive payments,

subsidies, or unrelated vocational training expenses.

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

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

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

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

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of agency status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Family Foster Care

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

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

Service Definition (Scope):

Assistance with ADL's, IADL's and supportive services provided in a licensed private home by a care provider that lives in the home. Adult family foster care is provided to adults who receive these services while residing in a licensed home. The total number of individuals who live in the home who are unrelated to the care provider cannot exceed 4.

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

Service must be provided in a licensed adult family foster care (AFFC) home and services are provided to the extent permitted under state law. To avoid duplication homemaker, chore, emergency response system, residential care, transitional care, attendant care, environmental modification, and non-medical transportation are not allowable service combinations for individuals receiving AFFC. Non- medical transportation is a component of AFFC and is included in the rate.

The cost of this service is limited up to a maximum of \$56.19 per day. Initially, AFFC rates were established to be comparable with the rates that providers charged their private pay clients for the same service. This cap may be increased as determined by legislative action. If the client's needs cannot be met within the allowed rate case management would explore other waiver service options with the participant including nursing home placement. The case manager makes participants aware of the service cap.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Foster Care

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

N.D.C.C. 50-11; N.D.A.C. 75-03-21

Certificate (specify):

Other Standard (specify):

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

Provider Qualifications

Entity Responsible for Verification:

ND Aging Services Division

Frequency of Verification:

Initial/and Re-enrollment every two years or upon expiration of Qualified Service Provider status whichever comes first, and/or upon notification of provider status change.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Attendant Care Service

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

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

Service Definition (Scope):

Hands-on care, of both a supportive and medical nature, specific to the needs of an individual who is ventilator dependent for a minimum of 20 hours per day; medically stable, as documented by their primary care physician at a minimum on an annual basis; has identified an informal caregiver support system for contingency planning with the assistance of the case manager; is competent, as documented by the primary care physician at a minimum of an annual basis, to actively participate in the development and monitoring of the plan of care.

Supportive services are those, which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Activities of Daily Living and Instrumental Activities of Daily Living may be furnished as part of this service.

A Nurse, licensed to practice in the State, will provide supervision of medical tasks. The frequency and intensity of supervision will be specified in the individual's written plan of care. For non-medical tasks not requiring supervision or delegation of a nurse, the individual (client) is responsible for the supervision of the tasks.

Services include nurse assessments, care planning, delegation, and monitoring quality of care to individuals receiving services in the home. The Registered Nurse or Licensed Practical Nurse are required to participate in the development of a plan of care for individuals who require assistance with maintenance of routine nursing-tasks. Other duty requirements include training and delegating of nursing tasks to an unlicensed assistive person(s) in accordance with the care plan, and may be individualized to clients need.

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

Attendant Care is limited to individuals who are ventilator dependent a minimum of 20 hours per day, must be medically stable as determined by a physician on an annual basis or as requested by the Department; have an informal caregiver support system for contingency planning; determined competent as documented by the primary care physician on an annual basis or as requested by the Department; to actively participate in the development and monitoring of the plan of care.

For consumers receiving Attendant Care Service, the cost is limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Department of Human Services. This cap may be increased as determined by legislative action. If the client's needs cannot be met within the allowed rate case management would

explore other service options with the participant including nursing home placement. The case manager makes participants aware of the service cap.

To avoid duplication homemaker, adult family foster care, adult day care, transitional care, respite care, and adult residential care are not allowable service combinations for individuals receiving attendant care. Non-medical transportation to transport the client is allowed. Escort to accompany the individual while they are being transported is not allowed, as it is a component of attendant care services.

Due to the complexity of the care provided to individuals receiving attendant care services, contingency plans are required as a prerequisite to receive this service to assure that health welfare and safety are maintained in the event that a provider is unavailable to provide the service.

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

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendant Care Service

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License (*specify*):

Individual- N.D.C.C. 43-12.1; N.D.A.C. (54-02, 54-05, 54-07)

Agency - N.D.C.C. 43-12.1; N.D.A.C. (54-02, 54-05, 54-07)

Certificate (*specify*):

Other Standard (*specify*):

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

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

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Individual - Initial/Re-enrollment every two years, and/or upon notification of provider status change.

Agency - Initial/Re-enrollment every two years, and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore

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

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

Service Definition (Scope):

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

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

Tasks are provided one-time or are intermittent and provided in the client's home. Chore service is not authorized if the tasks are the responsibility of the landlord. These services will be provided only in cases where the client or any other adult in the household is not capable of performing the activity.

Pre approval from the Department of Human Services is required if the cost of the service is expected to exceed \$200 per month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Agency & Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:Individual **Provider Type:**

Agency & Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**Individual - Demonstrating competency in chore standards - Enrolled Qualified Service Provider (QSP)
N.D.A.C. 75-03-23-07

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

Provider Qualifications**Entity Responsible for Verification:**

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:Other Service

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

Service Title:

Emergency Response

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

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

Service Definition (Scope):

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

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Emergency Response

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of agency status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

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

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

Service Definition (Scope):

Those physical adaptations to the home required by the individuals plan of care, which are necessary to ensure the

health welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps, and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and necessary for the welfare of the recipient.

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

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

For environmental modification the dollar limit is the lesser of the highest monthly rate for the highest cost skilled nursing facility or 20% of the tax evaluation of the home. The highest monthly rate for nursing facility is approximately \$10,000 per month in some rural areas this amount may be more than the market value of the home thus the 20% limit. This cap may be increased as determined by legislative action. Exceptions to this service cap will not be made. If the client's needs cannot be met within the allowed rate case management would explore other service options with the participant including nursing home placement. The case manager makes participants aware of the service cap.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Modification

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):

Agency only - N.D.C.C. 43-07, N.D.C.C. 43-09, N.D.C.C. 43-18

Certificate (specify):

Other Standard (specify):

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

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

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

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

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

Service Definition (Scope):

To enable individuals to access essential community resources or services in order to maintain themselves in their home and community.

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

With the exception of transitional care services, service tasks would not include transporting clients to/from work or school nor to facilitate socialization, to participate in recreational activities, or to medical appointments. This service is not available when transportation is provided as a component part of another services. State office staff review individual care plans to assure that the combination of services does not allow duplication of non-medical transportation.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:Individual **Provider Type:**

Individual & Agency

Provider Qualifications**License (specify):**

Individual - N.D.C.C. 39-06

Agency - N.D.C.C. 39-06

Certificate (specify):**Other Standard (specify):**

Individual-Individuals with valid drivers license, road worthy vehicle, clear driving records, and proof of insurance- Enrolled Qualified Service Provider(QSP) N.D.A.C. 75-03-23-07

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

Provider Qualifications**Entity Responsible for Verification:**

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Other Service

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

Service Title:

Specialized Equipment & Supplies

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

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

Service Definition (Scope):

Specialized equipment, supplies, 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 goods must not be attainable through other informal or formal resources.

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

The goods can only include the purchasing of items that relate directly to the client's care needs.

Goods requiring structural changes to the home are not allowed through this service.

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

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

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

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Equipment & Supplies

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of agency status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transitional Living

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

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

Service Definition (Scope):

Included is supervision, training, or assistance to the recipient with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living and mobility. Staff support including escort services is provided for supervision, independent living skills training until the interdisciplinary team determines this service is no longer appropriate.

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

A program that provides training for the recipient to live with greater independence in his/her home or apartment. Transitional living will be provided under this waiver if it cost-effective and if necessary to avoid institutionalization.

This service is provided only until independent living skills development has been met or until the interdisciplinary team determines this service is no longer appropriate. If the individual is unable to achieve independent living skills and remains eligible for state and federal funded services the care plan is reviewed by the case manager and the individual to transition them from transitional care to a combination of state plan and waiver services such as personal care, homemaker, escort etc.

To avoid duplication homemaker, respite care, adult day care, adult family foster care, residential care, and attendant care are not allowable service combinations for individuals receiving transitional care services.

Non-medical transportation to transport the client is allowed. Escort to accompany the individual while they are being transported is not allowed, as it is a component of transitional care services.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transitional Living

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

--

Certificate (*specify*):

--

Other Standard (*specify*):

Experience providing services to individuals with a diagnosis of brain injury - Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of agency status change

Appendix C: Participant Services

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

- b. Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, 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 Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).**

Complete item C-1-c.

- As an administrative activity.** *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:

--

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):

a) For Adult Family Foster Care (AFFC) providers and respite providers who provide care in an AFFC home only.

b) Providers are required to submit to both a State and Federal background checks unless they have resided in the State continuously for eleven years or since reaching age 18, whichever is less; or if they are on active US

military duty or have resided continuously in the State since receiving an honorable discharge.

c) N.D.C.C. 50-11 provides for nationwide, fingerprint based criminal background checks for AFFC providers and their respite workers. The AFFC licensure from the County Social Service Board monitors the need for a background check as part of AFFC licensing. Staff from Aging Services Division receive and review the background check requests to assure all required information has been included. The background checks are submitted to the Bureau of Criminal Investigation for completion. Once the background check is complete the reports are returned to Aging Services. If the report indicates an offense the report is reviewed by an attorney from the Legal Service Division to ascertain whether the conviction will have an effect on the ability of that person to provide care in an AFFC home as required in N.D.A.C. 75-03-21-09.1 Criminal - conviction - effect on licensure and operation of home.

Statutory authority to conduct background checks is limited to licensed AFFC providers and respite workers who provide care in an AFFC home.

- 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; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For individual service providers - Board of Nursing registry (licensed nurses or Unlicensed Assistive Persons (UAP's)); Health Dept's Certified Nurse Assistant's registry; Attorney General's Sexual Offender's registry and debarment database; Department of Human Services HCBS provider complaint/termination database; and for individuals providing Non-Medical Transportation – Department of Transportation for valid driving license.

For agency service providers - debarment database; Department of Human Services HCBS provider complaint/termination database. For newly enrolled service providers, the agency is responsible to assure direct service employees have met standards and requirements.

Appendix C: Participant Services

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

- c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
- i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Licensed Basic Care
Nursing Facility
Swing Bed Facilities

- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in

these settings.

Agencies that provide adult residential care maintain a community-based character by offering access to kitchen facilities; open dining and living room areas, transportation to community events, and activity programs. Meal programs are designed to accommodate individual choice.

The occupancy rate of the adult residential settings ranges from 7 to 24. The layout of each residential setting differs. Some of the settings are divided into smaller living areas and include separate dining, and recreational areas. Most of the agencies provide private rooms. The agencies that cater to individuals with dementia have a variety of security systems that are designed to assure resident safety; residents in these living arrangements are free to come and go with family and friends as they choose. Individuals can decorate their living space with their own possessions and may choose to have a personal phone.

Nursing facilities and hospital swing beds may not offer a home like atmosphere but the respite services provided in these settings is intermittent and limited in duration.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Basic Care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Case Management	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Adult Day Care	<input type="checkbox"/>
Adult Residential Care	<input checked="" type="checkbox"/>
Transitional Living	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Respite Care	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Emergency Response	<input type="checkbox"/>
Environmental Modification	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Adult Family Foster Care	<input type="checkbox"/>
Specialized Equipment & Supplies	<input type="checkbox"/>
Attendant Care Service	<input type="checkbox"/>

Facility Capacity Limit:

N/A - There is no limit on the licensing capacity of basic care facilities

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Nursing Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Case Management	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Adult Day Care	<input type="checkbox"/>
Adult Residential Care	<input type="checkbox"/>
Transitional Living	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Respite Care	<input checked="" type="checkbox"/>
Chore	<input type="checkbox"/>
Emergency Response	<input type="checkbox"/>

Environmental Modification	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Adult Family Foster Care	<input type="checkbox"/>
Specialized Equipment & Supplies	<input type="checkbox"/>
Attendant Care Service	<input type="checkbox"/>

Facility Capacity Limit:

N/A

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Swing Bed Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility

Case Management	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Adult Day Care	<input type="checkbox"/>
Adult Residential Care	<input type="checkbox"/>
Transitional Living	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Respite Care	<input checked="" type="checkbox"/>
Chore	<input type="checkbox"/>
Emergency Response	<input type="checkbox"/>
Environmental Modification	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Adult Family Foster Care	<input type="checkbox"/>
Specialized Equipment & Supplies	<input type="checkbox"/>
Attendant Care Service	<input type="checkbox"/>

Facility Capacity Limit:

Critical Access Hospitals (CAH) may not have more than 25 beds that can be used for inpatient care.

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

--

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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.

Payments are not made to legal guardians. Payments are made to family members who are enrolled as Qualified Service Providers for the services that they are authorized to provide to the client. Relatives may be paid to provide homemaker, respite, chore, adult day care, attendant care, environmental modification, and non-medical transportation.

Payment is made according to policy and is limited to the services listed on the care plan and the authorization

to provide service that is developed by the Case Manager. A copy of the authorization is given to the provider before they are eligible to provide the service. Some coding controls and edit checks are in place in the MMIS system. Additionally, Qualified Service Providers are required to maintain records and are subject to the review process.

- Other policy.**

Specify:

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

Any interested agency or individual may obtain a provider enrollment packet, upon request, from either the Department or the County Social Service Board. In addition, during community presentations, the State offers the opportunity for interested entities to receive enrollment packets. Consumers inform the County or State of interested parties and enrollment packet(s) are distributed. Advocacy organizations have encouraged interested entities to request enrollment packets and the Department responds to inquiries from potential providers and generates contacts to potential providers. Provider enrollment handbooks are also available on the Department's website.

The State has revised the enrollment packets to streamline the documentation and process. This process is periodically evaluated.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

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

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver

services authorized for each specific participant.

Furnish the information specified above.

Waiver services cannot exceed the amount equal to the highest monthly rate for the highest cost skilled nursing facility. This limit was determined to assure that services could be provided to individuals who require attendant care services. This amount may be adjusted upon legislative action. Exceptions to the service limit will not be made. If the individual's needs cannot be met within the service limit the case manager will work with the client to explore other options including admittance to a skilled nursing facility or other program that can meet their needs. The case manager informs the participant of the service limit. If an individual's needs exceed the service limit they would be issued a denial notice and would have the right to appeal.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Care Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*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. *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.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Entities and/or individuals that have responsibility for case management may provide other direct waiver services to the participant. Safe guards to ensure that service plan development is conducted in the best interest of the participant is evident when an individual or their legal representatives chooses a qualified service provider (QSP) from a list provided to them or recruits an individual who is willing to seek the designation as a QSP. The QSP list is updated by State office staff on a monthly basis and includes the following information: provider name and contact information, provider type, provider number, provider approved service(s) and applicable rates, and provider (approved) global endorsements. Individuals use the information on the list to make an informed decision.

Once an individual or their legal representative selects a provider they acknowledge on the care plan that they made an independent choice. In addition, the client is given a client's rights and responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

During client interviews, performed by the Department, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a provider is not aware of their rights it is addressed with the case management entity and included as a finding on the review report. The case management entity is then required to provide a corrective action plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Clients and or their legal representatives are active participants in the service plan development process. Case management is responsible to provide the client with information on the type of services available through various funding sources including the waiver. Clients choose the service that they feel will most appropriately meet their needs. When a client chooses waiver services, the client or their legal representative signs the explanation of client choice form. Definitions of the services that are available under the waiver are included on the back of the form. The document informs the client or their legal representative that they have a choice of receiving the services listed on the individual care plan or to receive services in a nursing home. It also informs them of their right to consult with whomever they wish before making this decision including family, friends and advocacy organizations.

Individuals are given a copy of the clients rights & responsibilities brochure it outlines client rights and responsibilities, and the case managers responsibilities. The individual care plan is developed with the client and or their legal representative and the case manager. Once developed the client or their legal representative signs that they are in agreement with the plan of care.

State office staff will pre-approve service plans that include; higher-level case management, environmental modification, specialized equipment, adult residential care, transitional care and attendant care. Cost proposals for environmental modification, specialized equipment, and attendant care are reviewed to assure that preliminary costs do not exceed the individual budget amount.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: SERVICE PLAN DEVELOPMENT (5 of 8)

- d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

When an individual applies for services the case manager initiates the care planning process by scheduling a meeting with the client and or their legal representative and any other individual that the client wants involved in the process. The case manager conducts a comprehensive assessment. The comprehensive assessment includes the following elements: Cover sheet (assessment information, client identification, demographics, informal supports, legal representatives, emergency contacts, medical contact information); Physical Health Information (nutrition, impairments, current health status, medications use); Cognitive / Emotional Status (cognitive behaviors, emotional well being/ mental health); Functional Assessment (activities of daily living, instrumental activities of daily living, supervised / structured environment/ special needs); Home Environment Physical Environment (physical environment); Services / Economic Assistance Information (services / funding sources).

Interim care plans may be developed for clients who are waiting determination of Medicaid eligibility or, who require services immediately, and the case management entity is not able to make a face to face visit on the day the service is requested. Interim care plans can begin the day that the client applies for Medicaid Waiver services and the case manager has preliminarily determined that they are functionally eligible based on collateral information. In addition they must verify that the client has submitted an application for Medicaid. Face to face contact must occur within 5 working days of the start date of the preliminary care plan to determine functional eligibility. The preliminary plan needs to be updated and signed by the client when both functional and financial eligibility is confirmed. When functional and financial eligibility for the waiver is confirmed the authorization to provide service is given to the provider and they are allowed to bill. An interim care plan is not an assurance that waiver services will ultimately be authorized. If it is determined that the client does not meet the functional or financial eligibility for waiver services they will be issued a denial notice and notified of their appeal rights.

All contacts relating to the client must be noted in the narrative section of the comprehensive assessment. Information that may be contained in the note includes the date, reason for contact, location of the visits, a description of the exchange between the case manager and the client or collateral contact, a list of identified needs, service delivery options, summary of the care plan, client stated goals, progress, or change in goals (must be documented at the initial, annual and six month contact), client satisfaction, follow up plans and the case managers initials.

Participants are informed of Home and Community Based Services that are available in their communities including services that are available under the waiver during the assessment process. Participant goals and needs are also discussed during the assessment and clients choose the type of service that will best meet their individual needs. In addition, client stated goals are documented on the individual care plan and reviewed with the client on a regular basis. On the individual care plan, the case manager lists other agencies and individuals who are providing services to waiver participants. Many waiver participants receive services through Older American Act programs and through the State Plan. The individual care plan lists the type of service, provider's name, units of service authorized, the provider's rate and the total cost of care. The case manager monitors the plan quarterly or more frequently if necessary. The care plan is updated on an annual basis and is reviewed at six months; both of these contacts must be face to face. In addition, the case manager is required to contact the client quarterly. Quarterly contacts may be conducted by telephone or face to face. Case management activities may occur more frequently if applicable.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Through the comprehensive needs assessment, potential risks are identified. The case manager and the client will review the assessment results and develop a care plan to diminish risk.

If a participant chooses an individual provider the client and the case manager establish a contingency plan that is documented on the individual care plan. The contingency plan may include contacting another provider, family member, community resource or if the service is not critical, rescheduling the service to be provided at another time. When individual providers enroll as qualified service providers they are required to state what they will do in the event that they are not able to provide the service as scheduled. If a participant chooses an agency provider it is the responsibility of that agency to send a replacement or if the service is not critical, to contact the client and reschedule.

Both individual and agency providers make assurances when they enroll with the Department that they will contact the Case managers when changes occur in the client's health status or service needs.

For Attendant Care Services, the nursing care plan must identify incidents reportable to the nurse on an immediate basis. Incidents that result in client injury or require medical care are reportable incidents to the nurse. The nurse is responsible to report these incidents to the case manager. If the incident signifies potential abuse, neglect, or exploitation, the Department will be contacted.

The State conducts case management reviews, provider reviews, and client interviews to identify inappropriate service delivery or actions and to address the client needs and satisfaction with the services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A Qualified Service Providers (QSP) list is maintained by State office staff and distributed to case management entities on a monthly basis. This list includes information about all providers who are currently enrolled to provide services. Case management entities are also informed of renewals, newly enrolled, and recently closed QSP's on a weekly basis thus assuring that clients have access to the most current list of providers available. The information contained in the QSP list includes: provider name and contact information, provider type, provider number, provider approved service(s) and applicable rates, and provider (approved) global endorsements.

This list is shared with the clients so they can choose a provider and used by the case managers to assure that providers are eligible to provide the type of service being authorized. The individual checks and signs the care plan indicating they were afforded the opportunity to choose their service provider(s).

When a change in service provider occurs between case management contacts – the client or legal representative may contact the case manager requesting the change in provider and the contact is verified in the case managers documentation. A copy of the updated care plan is sent to the client or legal representative.

Applicants/Clients may also recruit potential service providers. case managers often help individuals identify family, friends, neighbors etc. that may be willing to provide care. The potential providers must comply with provider enrollment standards and requirements. If a potential provider is identified the applicant may obtain a copy of the enrollment handbook at the local County Social Service office or may print a copy from the Department's website.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

All individual care plans are required to be forwarded to the State Medical Services Division/HCBS. An HCBS Program Administrator receives and reviews the care plans. Issues relating to inconsistencies or incompleteness are returned to the case management entity for resolution.

The comprehensive assessments/narratives are available through a web-enabled data system accessible to the Medical Services Division/HCBS staff.

These tools are used in case management reviews performed by the Department. The comprehensive assessment, individual care plans, authorizations, and other applicable information are used to determine services have been appropriately authorized by the case management entity.

The goal is to review case management entities each year (at a minimum) either through an on-site or desk review. The goal is to review 10% of the Medicaid waiver case files yearly. The Department employs two staff persons that are responsible for reviews.

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 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 §74.53. 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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case management entity is responsible to monitor the service plan and participant health and welfare. If the

client's care needs cannot be met by the care plan and health, welfare and safety requirements cannot be assured; case management must initiate applicable changes or terminate Waiver services. If the case is closed, the client is made aware of their appeal rights.

The client's legal representative, and family, also play a significant role in monitoring the care plan. The client or legal representative report changes to the case manager relating to the client's home, self, living arrangement, or service provision for care plan evaluation and revision.

Face to face contacts are required initially, semi-annually, and semi-annually thereafter. At least one home visit is required during the needs assessment process. A phone contact must occur at least quarterly. Case management (phone or on-site) contacts occur after 30 days from the initial care plan implementation and at least quarterly thereafter. Case management activities are not limited to quarterly contacts and additional contacts may be initiated when change is required in the care plan or a concern has been identified.

Monitoring methods are determined by reviewing the care plan. Care planning is a process that begins with assessing the client's needs. It includes the completion of the HCBS comprehensive assessment after which the case manager and client look at the needs and situations described in the comprehensive assessment and any other problems identified and work together to develop a plan for the client's care. All needs are identified in the comprehensive assessment and the services authorized to meet those needs are identified on the individual care plan. Additional information regarding needs and consumer choice is outlined in the narratives in the HCBS comprehensive assessment. For each functional impairment identified for which a service need has been authorized, a desired outcome and assistance required to achieve the outcome will be addressed in the notes/narrative section of the comprehensive assessment. For each ADL or IADL that is scored impaired and no waiver services have been authorized, the case manager documents how the need is being met. The case manager refers to the authorization to provide services form, to choose and discuss with the client the services and scope of the tasks that can be provided.

The HCBS case manager reviews with the client or the client's representative the following information about qualified service providers (QSP's) who are available to provide the service and who have the endorsements required to serve the client:

- Provider name and contact information
- Provider type
- Provider number
- Provider approved service(s)
- Applicable rates

The eligible provider selected by the client will be listed on the individual care plan. The service, amount of each service to be provided, the costs of providing the selected services, the specific time-period, and the source(s) of payment are also recorded on the individual care plan, and the authorization to provide service.

Contingency planning must occur if the QSP selected is an individual rather than an agency. The backup provider or plan must be listed on the individual care plan. Agency providers are required to coordinate staff to assure service availability.

The case manager shall review with all clients or the client's representative the client stated goal. The goal must be recorded on the individual care plan, and described in the narrative section of the comprehensive assessment on an annual and 6 month basis. The final step in care planning is to review the completed individual care plan with the client /legally responsible party and obtain required agreements/acknowledgments and signatures.

The case manager assures that services are implemented and existing services continued, as identified in the individual care plan. This activity includes contacting the QSP and issuing an authorization for service(s) form.

Service monitoring is an important aspect of care planning and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The case manager monitors the client's progress/condition and the services provided to the client. As monitoring reveals new information to the case manager, regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case manager shall document all service monitoring activities and findings in the client's case file.

When completing monitoring tasks if the case manager suspects a QSP or other individual is abusing, neglecting, or exploiting a recipient of HCBS an established protocol must be followed.

The case manager reassesses the client, care plan, and services on an ongoing basis, but must do a reassessment at six-month intervals and the comprehensive assessment annually. At the six-month and annual visit, the client stated goal must be reviewed and progress or continuation of the goal must be noted in the narrative of the comprehensive assessment.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Safeguards are in place to ensure that monitoring is conducted in the best interest of participants. The safeguards include the option for individuals or their legal representatives to choose a qualified service provider (QSP) from a list provided to them or to recruit an individual who is willing to seek the designation as a QSP. Once an individual (or their legal representative) selects the provider of their choice, they acknowledge on the care plan that they made an independent choice of that provider. In addition, the client is given a client's rights and responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

The Department conducts client interviews. Clients are asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a provider is not aware of their rights, it is addressed with the case management entity and included as a finding on the review report. The case management entity is then required to provide a corrective action plan to the Department.

The Department completes a review of each case management entity on an annual basis. If findings are identified corrective action plans are required. The Department also reviews all individual care plans to assure that the client has acknowledge their choice of provider.

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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An applicant requesting Home & Community Based Waiver services completes an application form. The application form contains information pertaining to consumer rights and explains the procedure clients may follow in the event they are not satisfied and wish to request a fair hearing. This form is signed and dated by the consumer or their legal representative.

Clients indicate on the care plan that they are in agreement with the services and have selected the service providers listed on the form. If the client is not in agreement with the care plan the case manager must provide them with a formal SFN 1649 HCBS Notice of Denial, Termination or Reduction form. The form includes contact information for the appeals supervisor. This document is signed and dated by the client or the legal representative at least every six months.

When an applicant/client is denied HCBS or if their services have terminated, they are also provided with the SFN 1649 HCBS Notice of Denial, Termination or Reduction form. If an applicant/client is denied or terminated, they are informed of the timeline necessary to submit an appeal. If a Medicaid appeal is received before the date of the termination is effective services can continue until a hearing decision has been made. If the Department's decision is upheld, the client will be required to reimburse the Department for services provided after the termination date.

Individuals are informed that they have an opportunity to request a fair hearing when they are not given the choice to receive waiver services, are denied waiver services or providers of their choice, or their waiver services are suspended, reduced or terminated.

On the individual care plan the client must check both: I am in agreement with the services and selected the service providers listed above and I am in agreement with this plan. If either of these two acknowledgments are not checked and signed by the client or the client's legal representative the client or the legal representative must be given a completed termination, denial or reduction form to inform the client of their right to a fair hearing.

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:

The Department of Human Services, Medical Service Division, HCBS Unit works with a multi-disciplinary team approach if a complaint/grievance is received. When HCBS complaint resolution personnel receive information, staff will assess the situation and arrange a team consult if needed.

At times, the team will be comprised of other HCBS team members, Medical Services Administration, Case Managers, Vulnerable Adult Protective Services, Health Department, Protection & Advocacy, and Long Term Care Ombudsman. Others may be involved depending on the situation.

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).

The department accepts any complaint received. When a participant notifies the State of a grievance or complaint, the complaint is received, evaluated, applicable records relating to the complaint are reviewed, collateral information is obtained from the involved persons, and resolution is sought. If the complaint identifies immediate risk or harm to the client, law enforcement is involved as appropriate. Other complaints are responded to based on severity or within 14 days. If the complaint is related to a denial / reduction / or termination of services the client is informed that this process is not a pre-requisite or substitute for a fair hearing.

A tracking system is maintained of the complaints, type of complaint, and the resolution.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. 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).

The State does not have a mandatory reporting law for reporting suspected abuse or neglect of an adult. However, the Department has written policies detailing the process of monitoring for abuse, neglect, or exploitation of waiver participants. Policy dictates that the case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the Department. When case managers become aware of an incident, policy requires that they gather specific information and report it to the appropriate party.

Incidents may include abuse, neglect, or exploitation as defined in policy. Abuse means the willful act or omission of a caregiver or any other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation to or of a vulnerable adult. Neglect includes the failure of an individual to provide the goods or services necessary to avoid physical harm, mental anguish, or mental illness. Exploitation is the act or process of an individual using the income, assets, or person of a resident for monetary or personal benefit, profit, gain, or gratification.

Depending on the situation, the case management entity could potentially report the incidents or suspicions to tribal entities, State Regional Human Service Centers, Vulnerable Adults Protective Services (VAPS), Long Term Care Ombudsman, Health Department, Protection and Advocacy, law enforcement, and/or the Department of Human Services. In addition these same entities report suspected abuse, neglect, or exploitation of waiver participants to case management entities and or the Department. This sharing of information helps to assure the timely resolution of concerns.

In between formal contacts by the case manager clients are made aware that they can contact the case manager to report any concerns. During the client interview conducted by the Department clients are asked if they know the name of their case manager and how to reach that individual. This helps to assure that the client will know whom to call to report an incident when one occurs instead of waiting until the case manager contacts them. In addition, family, friends, advocacy groups and other service providers report complaints to the case managers and or the Department.

Providers must also report critical incidents. Providers agree when they enroll to report potential abuse or exploitation when they become aware of the incident to the case manager.

Clients are provided with a copy of the client rights and responsibilities brochure. The brochure contains contact information for the case manager, appeal supervisor and the Executive Director of the Department of Human Services. Clients may contact either of these individuals or the state office to report an incident that involves the nurse or case management. If a complaint is received in regard to a nurse or case management entity state office staff work with the case managers supervisor and others to resolve the situation.

The incident could result in continued monitoring, termination of providers, removal of client from residences, arrest by law enforcement, or if allegations are not supported, the complaint is considered unsubstantiated.

The information is typically received via telephone or e-mail. However, information can also be obtained from letters, face-to-face contact, the review process, or through general discovery.

- b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The clients, or their legal representatives, will receive a client's rights and responsibilities brochure describing their rights and their responsibility to self-report when they are approved for services. Case managers list their name and contact information for the case management entity on the brochure.

For Attendant Care Service, the comprehensive care plan developed by the nurse manager will outline the critical incident reporting process.

- c. 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.

Case managers or others persons may provide a report of abuse, neglect or exploitation to the Department HCBS Program staff. The HCBS staff person follows through by working with the case manager to assist with the investigation of the complaint or concern identified. Depending upon the incident, there are several entities that are alerted about the allegations. If the accused person is not a provider, the complaint is referred to the Vulnerable Adults Protective Services (VAPS) for resolution. If the accused is a provider the Department HCBS Program staff person works with the case manager and determines a resolution. If the case involves an individual with Developmental Disabilities the DD Division and Protection and Advocacy are contacted for resolution. If the case involves Adult Family Foster Care (AFFC) clients the licensing agents responsible for AFFC licensing are contacted for resolution. If the case involves a client residing in a Basic Care or Assisted Living Facility the Long Term Care

Ombudsman is contacted for resolution and depending on the concern, the North Dakota Department of Health or the Departments Agent responsible for Assisted Living Licensure may be involved. If the complaint presents an imminent risk, or potential criminal activity is suspected, law enforcement is immediately contacted for resolution.

When an individual is receiving attendant care service, the delegating nurse and the case manager are responsible for gathering information and assessing the situation. If the critical incident is in relation to a health or medical critical incident (versus abuse, neglect, or exploitation), the nurse would report the incident to the State Program Administration upon discovery.

Policy dictates that case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the Department. Response time to all other complaints and concerns are responded to within 14 days.

The incident could result in continued monitoring, termination of providers, removal of client(s) from residences, arrest by law enforcement, or if allegations are not supported, it is considered unsubstantiated.

When appropriate, either the case manager or the Department will inform interested parties including the client or responsible party of the resolution of the complaint.

- d. **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.

With the addition to the information supplied in the previous sections, the State may also conduct on-site reviews of a service provider or on-site client interviews if there is an allegation of a critical incident.

If the incident involves the assistance of Protection and Advocacy, the Health Department or a Department of Human Services Long Term Care Ombudsman, the State will contact these individuals for assistance in the assessment/evaluation of the allegation. These various entities would then determine if separate on-site investigations should occur.

For attendant care service, the comprehensive care plan developed by the nurse manager will outline the critical incident reporting process. The nurse manager must report to the State Program Administrator incidents resulting in client injury.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

- a. **Use of Restraints or Seclusion.** (*Select one*):

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The ND Department of Human Services and the Department of Health monitor the use of restraints in residential facilities and through Adult Family Foster Care licensure. The Department of Human Services conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of restraints is part of the definition of abuse. Therefore, case 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. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

- The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- 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 Department of Health monitors the use of any type of restraints through the survey process in residential facilities. The Department of Human Services HCBS programs do not allow or approve the use of restraints for any waiver service. If restraints are used the case manager reports the incident to the Department of Human Services and the protocol for abuse and neglect is followed.

- 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-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.

Basic Care Facilities that provide Adult Residential Services have ongoing responsibility for medication regimen based on their Basic Care Licensure.

- Each Basic Care facility is licensed annually by the Department of Health, Division of Health Facilities.
- Onsite surveys are conducted each year on approximately 1/3 of the Basic Care Facilities.
- Basic Care survey process consists of several tasks as listed below.

Task 1 - Offsite Survey Preparation

Task 2 - Entrance Conference/Onsite Preparatory Activities

Task 3 - Initial Tour

Task 4 - Sample Selection

Table 1 - Survey Procedures for Basic Care - Resident Sample Selection see table below.

Res. Cencus	Sample Size	Res.Rev.	Clsd Rec	Rev.	Res.Interviews
1-30	5	5	1	3-5	
31-60	10	10	2	6-10	
61-90	15	15	3	11-15	
91-115	20	20	3	16-20	

Task 5 - Information Gathering

Sub-Task 5A - General Observations of the Facility

Sub-Task 5B - Kitchen/Food Service Observation

Sub-Task 5C - Resident Review Interview - 5 residents (per surveyor)

Sub-Task 5D - Quality of Life Assessment

Sub-Task 5E - Medication Pass – See below

Sub-Task 5F - Fire Safety

Task 6 - Information Analysis for Determination of Compliance

Task 7 - Exit Conference

- All onsite surveys are conducted without announcing the survey to the facility.
- Complaints are received by the Division in any form, (phone, email, us mail, in person etc) and are investigated by unannounced onsite visits.
- When non-compliance is identified by survey staff, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all five components of a plan of correction are represented in the plan.
- Revisits are conducted on all citations to verify implementation of the plan of correction and that the implementation has indeed corrected the problems identified.

- All Basic Care facilities are surveyed ever two years for compliance to life safety code requirements.
- As an example of how the survey process is conducted, included below is the medication pass portion of the basic care facility survey.

Sub-Task 5E – Medication Pass

A. General Objective

The general objective of the medication pass is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice.

B. General Procedures

Record observations. Record the physician's actual order. Do this only if the physician's order differs from the observation of the administration of the drug. When observing the medication pass, do the following:

- Be as neutral and unobtrusive as possible during the medication pass observation.
- Observe a minimum of 10 opportunities for errors (opportunities are both the drugs being administered and the doses ordered but not administered). Strive to observe as least two individuals administering medications if possible. This provides a better overall picture of the accuracy of the facility's entire drug distribution system. Ask the person administering the medication if they know what the medication is and what it does. Ask how the person was trained to administer medication. Ideally, the medication observation could include residents' representative of the care needs in the sample. This would provide additional information on these residents, and provide a more complete picture of the care they actually receive. For example, if blood sugars are a problem, insulin administration may be observed. If eye infections are a problem, antibiotic eye drops may be observed, if residents are in pain, as needed pain medications may be observed, etc. Observe different routes of administration, i.e., eye drops, injections, inhalation. The opportunities should equal 50% of the resident census, not to exceed 40 opportunities.
- Verify the training and competency of the person who administered the medications.
- There is an enforcement process that can be applied to basic care facilities that are unwilling or unable to achieve and maintain compliance. Facilities are subject to one or more enforcement actions, which include: A ban or limitation on admissions, suspension or revocation of a license, or a denial to license, for the following reasons:
 - (1). Noncompliance with the requirements of this chapter have been identified which:
 - (a) Present imminent danger to residents. These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department;
 - (b) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or
 - (c) Have a potential for jeopardizing resident health, safety, or security if left uncorrected.

Swing bed facilities that provide respite care have ongoing responsibility for medication regimen based on their licensure as a hospital.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities.

Hospital swing bed facilities must follow the hospital or CAH conditions of participation in addition to swing bed requirements.

Onsite surveys are conducted based on criteria set by the Centers for Medicare and Medicaid Services (CMS). Workload is based on Tiers. Tier 4 workload is lowest priority and requires new Critical Access Hospitals to be re-surveyed 12 months after the initial survey. Tier 4 also requires hospitals to be surveyed every 3 years. Tier 3 workload requires hospitals to be surveyed every 4.5 years and Tier 2 requires survey of hospitals that have not been surveyed for 6 years. Tier 2 also includes surveys of hospitals that CMS has identified as those hospitals most at risk of providing poor care.

All surveys, including complaints, are conducted without announcing the survey to the facility.

Hospital survey process consists of several tasks as listed below.

- Task 1 – Offsite Survey Preparation
- Task 2 – Entrance Activities
- Task 3 – Information Gathering/Investigation
- Task 4 – Preliminary Decision Making and Analysis of Findings
- Task 5 – Exit Conference
- Task 6 – Post Survey Activities

All surveys include record review, interviews and observation of care and services provided.

When non-compliance is identified by survey staff, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all components of a plan of correction are represented in the plan.

Revisits are conducted on all deficiencies to verify implementation of the plan of correction and that the implementation has corrected the problems identified.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

North Dakota Department of Health is responsible for oversight of Basic Care Facilities.

Sub-Task 5E – Medication Pass

A.General Objective

The general objective of the medication pass is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice.

B.General Procedures

Record observations. Record the physician's actual order. Do this only if the physician's order differs from the observation of the administration of the drug. When observing the medication pass, do the following:

- Be as neutral and unobtrusive as possible during the medication pass observation.
- Observe a minimum of 10 opportunities for errors (opportunities are both the drugs being administered and the doses ordered but not administered). Strive to observe as least two individuals administering medications if possible. This provides a better overall picture of the accuracy of the facility's entire drug distribution system Ask the person administering the medication if they know what the medication is and what it does. Ask how the person was trained to administer medication. Ideally, the medication observation could include residents' representative of the care needs in the sample. This would provide additional information on these residents, and provide a more complete picture of the care they actually receive. For example, if blood sugars are a problem, insulin administration may be observed. If eye infections are a problem, antibiotic eye drops may be observed, if residents are in pain, as needed pain medications may be observed, etc. Observe different routes of administration, i.e., eye drops, injections, inhalation. The opportunities should equal 50% of the resident census, not to exceed 40 opportunities.
- Verify the training and competency of the person who administered the medications.
- There is an enforcement process that can be applied to basic care facilities that are unwilling or unable to achieve and maintain compliance. Facilities are subject to one or more enforcement actions, which include: A ban or limitation on admissions, suspension or revocation of a license, or a denial to license, for the following reasons:
 - (1). Noncompliance with the requirements of this chapter have been identified which:
 - (a) Present imminent danger to residents. These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department;
 - (b) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or
 - (c) Have a potential for jeopardizing resident health, safety, or security if left uncorrected.

The North Dakota Department of Health is also responsible for the oversight of hospital swing bed facilities.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Swing bed facilities must follow the hospital or CAH conditions of participation in addition to swing bed requirements.

All surveys are conducted using an outcome oriented survey process and include record review, interview and observation.

The Hospital Conditions of Participation require pharmaceutical services meet the needs of the patients' by promoting a safe medication use process that ensures optimal selection of medications, dose, dosage form, frequency, route, duration and that substantially reduces or eliminates adverse drug events and duplication of treatment.

The Critical Access Hospital Conditions of Participation also require rules for storage, handling, dispensation and administration of drugs and biologicals. The CAH must ensure the safe and appropriate use of medications and medication-related devices.

Hospital licensing rules require compliance with the pharmacy requirements. When non-compliance is identified by survey staff, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all components of a plan of correction are represented in the plan.

Revisits are conducted on all citations to verify implementation of the plan of correction and that the implementation has corrected the problems identified.

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)*

- 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).

North Dakota Department of Health is responsible for oversight of medication administration in Basic Care Facilities N.D.A.C. 33-03-24.1-10. Protocol provided in G-3-b-ii.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Hospital licensing rules require compliance with the pharmacy requirements. Protocol provided in G-3-b-ii.

Medication administration for attendant care is delegated to the attendant care service provider by a licensed nurse and this activity is governed under N.D.A.C. 55-05-04 of the Nurse Practice Act.

For all other waiver services N.D.A.C. 75-03-23-07 and the Qualified Service Provider handbook outline the standard for self-administration of medication. A definition of self-administration is located on back of the SFN 1699 Authorization to Provide Service form that is given to a provider prior to the implementation of service provision. The definition on the back of the form reads, medication assistance is limited to assisting with client self administration of routine oral medications by doing the following: opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container.

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:

Required to record all errors.

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.

North Dakota Department of Health is responsible for oversight of medication administration in Basic Care Facilities N.D.A.C. 33-03-24.1-10. Protocol provided in G-3-b-ii.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Hospital licensing rules require compliance with the pharmacy requirements. Protocol provided in G-3-b-ii.

Medication administration for attendant care is delegated to the attendant care service provider by a licensed nurse and this activity is governed under N.D.A.C. 55-05-04 of the Nurse Practice Act. The nurse gives instructions for medication administration and the nurse is responsible for on-going supervision of the delegated activity.

For all other waiver services N.D.A.C. 75-03-23-07 and the Qualified Service Provider handbook outline the standard for self-administration of medication. A definition of self-administration is located on back of the SFN 1699 Authorization to Provide Service form that is given to a provider prior to the implementation of service provision. The definition on the back of the form reads medication assistance is limited to assisting with client self administration of routine oral medications by doing the following: opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container. If incidents are reported relating to self-administration of medication they are handled through the compliant process.

Appendix H: Quality Management Strategy (1 of 2)

Under §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 Management 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 Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Quality Management Strategy 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 identify the other long-term services that are addressed in the Quality Management Strategy.

Appendix H: Quality Management Strategy (2 of 2)

Attachment #1

The Quality Management Strategy for the waiver is:

The State has a Quality Assurance Plan that identifies key components and practices of the quality framework methodology. Within this working document, the following guidelines are monitored: Level of Care Determination - Consistent with Need for Institutionalization, Plans of Care - Responsive to Waiver Participant Needs, Qualified Providers - Serve Waiver Participants, Health & Welfare of Waiver Participants, State Medicaid Agency - Retains Administrative Authority over the Waiver Program, and Provision of Financial Accountability for the Waiver.

In order to evaluate the effectiveness and outcomes of the above guidelines, the State has adopted a method by using discovery, remediation, improvement plans, and evaluation of effectiveness.

The home and community base services team (HCBS) team includes all staff members of the Medical Service Division - HCBS, the Managed Care/PACE/Disease Management Program Administrator, the LTC Program Administrator, the State Unit on Aging Director, and Assistant Medical Services Director.

The core HCBS team consists of the Assistant Medical Services Director who has overall responsibility for the team, 4 HCBS Program Administrators and 2 support staff. One Human Service Program Administrator IV (HSPA IV) is the team lead and administers policies and program for all services. This individual supervises the Human Service Program Administrators III (HSPA III) positions. They are responsible for QSP enrollment, the review process, complaint resolution, and quality assurance. The other HSPA IV position is responsible for waiver administration, administration of state funded services, QSP rate setting, and supervision of support staff.

Level of Care:

Discovery includes a review of case management records by the HCBS reviewer or another member of the HCBS team; case management entities are reviewed on an annual basis either on site or via desk audit. On site and desk reviews are alternated every other year. On site audits may also be conducted if numerous corrective actions have been identified or if the case management entity has new staff that require on site technical assistance.

Do to the limited number of waiver recipients an effort is made to pull waiver client files. For all elements of the quality assurance plan the goal is to review 10% of waiver client case files. The percentage is based on an average number of current active waiver cases.

(A) The following questions in the case management review-guide are utilized for discovery related to LOC assurances.

1. Is a nursing facilities level of care current and on file?
2. Was the client offered a choice of institutional or HCBS services?
3. Is there documentation that the recipient is not eligible for the Medicaid waiver?
4. Was the comprehensive assessment completed accurately?
5. Does the ICP list services applicable to the assessed needs?
6. Are 30 day monitoring contacts completed?
7. Are quarterly monitoring contacts completed?
8. Are 6-month monitoring contacts completed?

The goal for these questions is less than a 5% error rate for responses that meet all elements of the question and less than a 10% error rate for partially correct responses. The report to evaluate the rates is completed on an annual basis.

When pre-determined (QA) goals are not met, the State will discuss the issue at team meetings and develop a plan of action. The results of the data are also published in the HCBS Update and provided to Case Management entities. If goals are unmet, the issue will be addressed further in the next Case Management training. Policy/protocol are updated as applicable.

(B) Objective-assure payment does not continue when LOC screenings end. Dual Diagnosis Management (DDM is the contracted entity for LOC Determination) provides a quarterly report indicating current LOC screenings are on file. This report is evaluated to assure payment does not continue when LOC screenings end. Additional documentation that may be applicable is also reviewed from the case files. DDM also sends reminders to the case management providers when the LOC screening is due. Program Administrators follow-up directly with the County and/or service provider when there is an issue. The improvement plan may include letters to providers requiring them to make payment adjustments or recoupments.

(C) Objective-Assure case managers understand the LOC screening process. Input from providers relating to the

understanding of the LOC process is accepted on an ongoing basis. The Adult Services Committee, which includes Case Managers, County Directors and a member of AARP, have been asked for direct input. Improvement plans include training, involvement of the Adult Services Committee in the orientation process for new case managers, and updating policy and forms.

Plan of Care

Discovery includes a review of case management records by the HCBS reviewer or another member of the HCBS team; case management entities are reviewed on an annual basis either on site or via desk audit. Do to the limited number of waiver recipients an effort is made to pull waiver client files. For all elements of the quality assurance plan our goal is to review 10% of waiver client case files. The percentage is based on an average number of current active waiver cases.

(A) The following questions in the case management review-guide utilized for discovery related to plan of care assurances include:

1. Are outcomes documented following an ADL or IADL that has been scored impaired for which a HCBS service is provided?
2. Are goals documented on all clients?

The goal for these questions is less than a 10% error rate for responses that meet all elements of the questions and less than a 20% error rate for partially correct responses. The report to evaluate the rates is completed on an annual basis. When pre-determined (QA) goals are not met, the State will discuss at team meetings and develop a plan of action. The results of the data are also published in the HCBS Update and provided to Case Management entities. If goals are unmet, the issue will be addressed further in the next Case Management training. Policy/protocol are updated as applicable.

(B) Objective-develop a tool to collect consumer input, partner with other agencies to gather input. Input hearings were held at 13 sites throughout North Dakota. Of the 1,106 respondents, 131 (11.8%) reported residing on a reservation or in an Indian Service Area. Spirit Lake Reservation had the highest percentage with 4.2% of respondents. Surveys were completed by participants on site which asked for input on services needs and surveys were given to case managers and outreach workers to be provided to home bound consumers to complete and return. The improvement plan is to look for grants and other opportunities to provide services. The goal is to develop programs that meet consumer needs. This process is ongoing.

(C) Objective- Assure a significant number of client files that receive MW services are reviewed. The quality assurance plan includes both state and federally funded services. The goal is to review approximately 10 % of the clients receiving waiver services. The HCBS Program Administrator that is responsible for reviews does focus on assuring a significant number of waiver case files are reviewed. A report to assure the number is significant is run annually. The number is not based on a statistical calculation, due to the small number of clients that receive waiver services and resources limitations. The number will be reviewed (the Quality Assurance Plan is new) as history with the Quality Assurance Plan is established. Also 53 counties are reviewed annually and many of the smaller counties do have current waiver clients.

When pre-determined goals are not met, the State will discuss the issue at team meetings and develop a plan of action. The results of the data are also published in the HCBS Update. Tools and/or instruments are revised to accommodate new measures. Policy/protocol are updated as applicable.

Qualified Service Providers

Discovery includes a review of Qualified Service Provider (QSP) records by the HCBS reviewer or another member of the HCBS team. The goal is to review approximately 5% of the providers on an annual basis via desk audit. The focus is to audit providers that are out of compliance with enrollment agreements or require technical assistance. The list of providers targeted is generated from payment records, requests by case managers or through other concerns that may be identified.

(A) The following questions in the QSP review-guide are utilized for discovery related to plan of care assurances.

1. Do agency staff meet competency standards?
2. Is the QSP qualified to provide client specific endorsements?
3. Is the QSP qualified to provide global endorsements?
4. Did the QSP maintain accurate records of service delivery?
5. Does the QSP retain records for a minimum of 42 months?
6. Were services delivered in accordance with the SFN 1699 (authorization to provide service)?

7. Did the QSP's documentation correlate with the payment history?
8. Did the QSP bill at the agreed upon rate?
9. Did the QSP use the correct procedure code?
10. Did the QSP bill within the amount authorized by the case management agency?

The goal for these questions is less than a 10% error rate for responses that meet all elements of the question and less than a 20% error rate for partially correct responses. The report to evaluate the rates is completed on an annual basis. This goal will be reviewed in January 2007 and re-evaluated as a result of the focus of reviewing providers with an identified irregularity or concern.

When pre-determined goals are not met, the State will discuss the issue at team meetings and develop a plan of action. The results of the data are also published and provided to Case Management entities. Annual letters are sent to all providers updating information and requirements. Tools and/or instruments are revised to accommodate new measures. Case Managers and other service providers are notified of actions when applicable. If improper payment activities have occurred, adjustments to claims are processed.

(B) Objective-Providers understand the responsibilities of enrolling as a QSP and complete forms correctly. Information and input is accepted from providers, team members, and case managers review the handbook prior to publishing. Handbooks are updated as needed. Annual instruction letters are sent to providers. The goal is to make the enrollment process simple and clear for providers. This goal is evaluated on an ongoing basis.

(C) Objective-Assure the protocol used to enroll QSP's is comprehensive and assures the provider meets the standards. The complaint log is evaluated annually to determine effectiveness of the protocol used to enroll providers. The improvement plan includes updating protocol. Termination of providers and recoupment of funds is also part of the plan when appropriate.

Health & Welfare

Discovery includes a review of questions in the Client Interview Guide completed with the client in the client's residence by the HCBS reviewer or another member of the HCBS team. The goal is to interview 5% of clients annually that receive services under the Medicaid Waiver Program.

(A) The following questions in the Client Interview Guide QSP review-guide are utilized for discovery related to health and welfare assurances.

1. Does the QSP complete all tasks as approved on the SFN 1699 (authorization to provide service)?
2. Do the services offered meet your needs?
3. Are all tasks done according to your expectations?
4. Is the QSP respectful to you and conscientious with your property?
5. Were you offered a choice of provider?
6. Are you aware you can change provides as you choose?
7. Do you know your case managers name and how to reach that individual?
8. Were you involved in the development of your care plan?
9. Are you satisfied with your access to community activities?
10. Do you feel your social needs are met?

The goal for these questions is less than a 10% error rate for responses that meet all elements of the question and less than a 20% error rate for partially correct responses. The report is monitored on an annual basis. The results are published in the HCBS Update and electronically sent to all case managers. A client's right brochure has been developed and a policy will be implemented January 1, 2007 requiring the brochure to be given to all HCBS consumers.

(B) Objective- Assure case managers are aware of the protocol to report complaints. The plan includes a review of this aspect of the policy during the new case manager training. A policy issuance was developed to clarify the process and policy has been updated. Evaluation is ongoing and input is accepted from the Adult Services Committee and team members.

(C) Objective-Identify and remediate trends in the complaint log. The complaint log is reviewed to evaluate who provides the complaint, nature of the complaint, and resolution. It was discovered that a new field needed to be added to the resolution section to allow for better analysis. Discussion is held at team meetings to evaluate the process. The reports related to this objective are run on an annual basis. The next report is due March 2007. Team members will evaluate the process for viable data and information.

(D) Objective- Assure a significant number of clients that receive services under the Medicaid waiver program are interviewed. A report is run on an annual basis to evaluate if this goal is met. During the review process the team member responsible for reviews makes an effort to target clients who are receiving services under the Medicaid Waiver. The results are reviewed at the team meetings.

The number is not based on a statistical calculation, due to the small number of clients that receive waiver services and resources limitations. About 5% of waiver clients are interviewed which is about 25% of all consumers interviewed for the Quality Assurance plan (the plan includes both state funded programs and waiver programs).

State's Administrative Authority and Financial Accountability

(A) Objective- Evaluate and review payment and actions to reduce inaccurate claims for payment. A quarterly report has been developed to assist in evaluating if the correct criteria are being followed in the establishment of spousal impoverishment benefits.

Based on the results of the report, case managers are contacted and payment records re reviewed.

(B) Objective- Strengthen audit process. This is an ongoing process. An additional staff member became a member of the HCBS team in March 2006 to assist with reviews. Technology has been used to enhance the review process. A database has been developed to record billing and payment problems. Frequently found errors noted in the review process are published in the HCBS Update.

Reviews and audits of case management entities, QSPs, and client interviews are a key component of the Quality Assurance Plan.

The Case Management review/audit process identifies findings that require the Case Management entity to provide a written corrective action plan and or provide copies of the required information. The review process utilizes case management records, payment histories, SAMS reports, and MMIS data.

The review/audit process for QSP's also identifies findings that may result in recoupment of funds, provision of technical assistance, termination of the provider or a written corrective action plan. The review process utilizes QSP records, payment histories, MMIS data, and may include case management records.

The client interview process utilizes case management records, the client's statements, observation of the environment, observation of the client's physical appearance, and input from family members present at the interview. Interview results that identify a concern may be reviewed with the case management entity or result in activating the protocol followed in complaint resolution.

The HCBS Unit of the ND Medical Services Division has partnerships with other Units within the Medical Services Division. External resources are vital to the development of effective and efficient services. These entities participate as applicable: County Social Service Boards, service providers, family members, consumers, Home Health Agencies, Long Term Care Association, advocates, and other interested parties.

With any working document, the above guidelines and goals are evaluated and the measurements are accordingly revised or adjusted. Goals will be able to be measured to identify improvement or additional modifications to the QA plan or HCBS process. Additionally, issues and policy compliance that may need to be monitored may be added to the plan and issues that no longer are an identified concern, will be removed from the plan.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Human Services currently has 1710 enrolled Qualified Service Providers including case management entities. A minimum of 5% or 85 entities are reviewed annually. The process to choose who will be reviewed is not random. The providers are chosen because irregularities in their billing patterns or other concerns have

been identified. The Department of Human Services provider review process consists of the evaluation of payment histories, county case management records/activities, and provider records. Within these reviews, various components are evaluated to determine if activities and tasks were billed/paid within allowable limits. Provider records and logs are evaluated to determine if proper procedure codes were utilized, client's needs were properly identified, and services were delivered in accordance with assessment findings.

In addition, all case management entities are reviewed annually to assure that case management payments were for services that were actually provided and are in accord with Department standards.

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 Human Services is performed every two years. This audit is a result of the statutory responsibility of the State Auditor to audit each state agency once every two years and is a report on internal control, on compliance with State and Federal laws, and on efficiency and effectiveness of agency operations.

The State Auditor's Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

Appendix I: Financial Accountability

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).

With the exception of Case Management, Adult Family Foster Care and Transitional Care, the rates are established in the following manner:

Agency rates were initially established in 1990. The rates were based on actual cost reports. The rates have since increased based on legislative action. Agency providers, which may include public and private entities, are still required to forward agency cost reports at the time of enrollment. Direct, indirect, and administrative costs are provided to the State for rate determination. The agency cost reports are reviewed for reasonableness and a provider rate is established. Reasonableness is determined by evaluating whether reported costs are client related and necessary to the provision of the service. Rates are also reviewed against pre-determined limits established by the State. Agency rates may not currently exceed \$4.48 per 15-minute unit. If the rate that was determined by reviewing the cost report is within the pre-determined limit, the agency is issued that rate. If the agency rate is greater than the pre-determined limit, the rate is reduced. Rates may be increased by legislative action.

Individual provider rates were also initially established in 1990. The caps on rates were initially established after considering the following information: minimum wage inflated by 30% to cover administrative costs, the mean wage that was being paid to individuals who were currently providing waiver services and Job Service information about the average salary paid in North Dakota for similar work. The rates have since increased based on legislative action.

When an independent, self-employed service provider enrolls as a QSP, the individual provides an initial request for a rate. If the rate is within pre-determined limits established by the State, the provider is issued the rate requested. Currently the maximum rate allowed for individual provider's is \$2.77 per 15-minute unit. If the individual's rate is greater than the pre-determined limit, the rate is reduced. Rates may be increased by legislative action.

The cap for agency rates is higher because they are based on actual costs and include allowable administrative costs

to the agency. Allowable administrative costs include the indirect cost of providing services such as telephone, billing, recruitment costs and office space. Currently administrative costs in excess of 15% of the direct care costs for providing services are excluded when calculating the rate.

For providers of Adult Family Foster Care (AFFC) and Transitional Care, provider rates are determined based on a formula and factor based system. This system takes into consideration the tasks required to care for specific clients. Each allowable task has an identified point factor. The total points are multiplied by a factor, which is unique to the specific service. The factor formula then calculates a daily rate. The daily rate assigned takes into consideration the established limit for AFFC. The limit is defined in Section C. If the rate is at the limit or less, the provider is notified of the assigned rate. If the rate is greater than the limit, the rate is reduced and the provider is notified of the rate.

Case management rates were initially established in 1984. A committee established the rates based on the average salary being paid to social workers at that time and other information provided by the case management entities. In the early 1990's case management rates were reviewed and increased based on the cost of providing services at that time. Each case management entity receives the same rate for providing case management services. Rates have since been increased based on legislative action.

There is a higher rate for case management services based on difficulty of care factors. Due to the complexity of certain cases and time required, the higher case management rate can be used if a case requires case management participation in care plan meetings with an interdisciplinary team on a regular basis or a for a case that requires frequent face to face visits to assist care plan development and monitoring. Case managers must get prior approval from the Department of Human Services before they can bill using the higher-level case management rate.

The general rate for case management for an initial / annual contact is \$161.21 and \$87.46 per quarterly or other contact. The higher-level case management rate is \$229.71 for the initial / annual contact and \$87.46 for the quarterly or other contact.

Providers are also notified they must charge private pay clients at a rate equal to, or greater than, the rate established with the State. In all cases, the provider is notified of the initial rate and is notified when the rate changes.

Individuals and agencies are required to enroll as Qualified Service Providers (QSP) with the Department of Human Services. All QSP's are considered independent contractors. When an individual or agency enrolls as a QSP they indicate the county or counties where they are willing to provide service. A QSP list is maintained by the Department and provided to waiver participants by the case manager. The client can choose any approved provider from the list.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All providers are required to complete requests for payments on turnaround documents. These documents are offered in two formats – paper and electronic. Both formats require the turnaround documents to be processed through the Medicaid Management Information System (MMIS). Turnaround documents go directly from the provider to MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. Public agencies do not certify expenditures for waiver services.**
- Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public 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 public 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 Non-State Public Agencies.

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Medicaid payment system will deny claims if the individual is not an approved Medicaid recipient. The State receives reports from Dual Diagnosis Management identifying individuals screened eligible for the waiver and the information including the eligibility period of the screening is entered into the MMIS. The system will deny any claim for waiver services that does not have a valid screening for the dates of service payment is requested.

To assure proper claims payment, the Department conducts post payment audits to evaluate payments for accuracy, accountability and reasonableness. This includes an evaluation of the comprehensive assessment and the results are compared to the authorization to provide services and the client's service plan. The payment histories are cross-referenced with provider records. Inadequate records and inaccurate requests for payments are reported to the providers and findings and corrective actions are required. Payments that are in excess of what is authorized or are unallowable are recouped by the State. The recoupments are made through a provider adjustment or direct provider payment.

- 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 §74.53.

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 pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. 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 Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

- No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

County Social Service Boards (Case Management, Respite Care, Homemaker Service, Non-Medical Transportation, Chore Service) North Dakota Indian Tribal entities also may enroll to provide services for which they are qualified to provide and choose to provide.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to Public Providers.

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to public providers is the same as the amount paid to private providers of the same service.**
- The amount paid to public 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 public providers differs from the amount paid to private providers of the same service. When a public 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 do not receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- 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.** *Select one:*

- 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 §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 §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 §1915(b)/§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 §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

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 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 public 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 public 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 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 non-State level sources of funds for the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Revenues.**

Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:

- Other non-State Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the 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 public 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) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *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:

- Provider taxes or fees**
- Provider donations**
- Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Provider agency cost reports separately identify the costs of room and board. The room and board expenses are not included when determining the provider rate. Providers of service are responsible from collecting room and board directly from the client.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.
 - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii

through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**
 - ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.**
 - iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.**
 - iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d 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	6743.36	17593.00	24336.36	52806.00	1575.00	54381.00	30044.64
2	6805.73	18208.00	25013.73	55446.00	1630.00	57076.00	32062.27
3	6898.85	18845.00	25743.85	58219.00	1687.00	59906.00	34162.15
4	7131.63	19505.00	26636.63	61130.00	1746.00	62876.00	36239.37
5	7272.34	20188.00	27460.34	64186.00	1807.00	65993.00	38532.66

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 Number 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	400		400
Year 2	427		427
Year 3	454		454
Year 4 (renewal only)	481		

		481
Year 5 (renewal only)	508	508

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average of length of stay was calculated by using state generated reports (SB9-810-AA and BB). These reports show the total number of days of waiver coverage for the last full year of coverage for the previous Elderly and Disabled and TBI waivers. The reports also show the unduplicated count of recipients on each of the waivers during that period of time. The data from the two reports were combined and an average length of stay was calculated. The average blended length of stay for the combined data is 276 days. We anticipate that the average length of stay for this Waiver will remain the same as the length of stay for the blended waivers calculated above.

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 for these estimates is as follows:

The current Elderly and Disabled waiver was modified to eliminate personal care services. As a result the number of recipients on that waiver was reduced by more than 25%. This change also affected other services covered in the waiver. Therefore the Form 372 reports from the Elderly and Disabled and TBI waivers are not a good representation of anticipated services for this waiver. The Department relied on recently generated reports that detail the recent history of services including number of services provided, cost per service provided and the number of recipients utilizing each service. This information was used as the primary source of information to complete this section of the waiver. The 372 reports were used only if other data was not available. These reports and a narrative on how the information was compiled are available if requested.

Growth in the number of services was based on the anticipated growth in the number of waiver recipients of 7% per year for most services. In those instances where the services were small in number and residential services only one recipient was increased each year. For services that are calculated on a half-day, hourly or 15-minute unit basis, a 1% utilization increase was included for each year of the waiver in anticipation of an increase in the number of services that each recipient will use over the course of the waiver. This is based on the anticipation that individuals with a need for additional services will enter the waiver in the future. No utilization increase was made for attendant care services because it is a 24-hour service. Units were also increased for case management to 5 in the last two years of the waiver in anticipation in the growth in the frequency of case management visits. An inflation factor of 3.5% per year was added to each service. This factor is based on historical rate increases given to providers.

When calculating Environmental Modification and Specialized Equipment and Supplies, a base project dollar amount was used and then inflated forward. The inflation rate used was 3.5%.

- 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 most recent 372 report for the Elderly and Disabled Waiver indicates that the estimated cost of all other

services paid on behalf of waiver recipients averaged \$5,927. This included the cost of drugs that in many cases are no longer paid by Medicaid because Part D Medicare was implemented in January 2006. The Department ran a separate report that indicates the average cost reduction due to Part D implementation averaged \$2,839 per recipient. Therefore we are adjusting downward the initial estimate to \$3,088. In addition, the movement of personal care services to the regular Medicaid Program increases the cost of this service to waiver recipients. It is estimated that the average yearly cost for personal care services for waiver recipients is about \$13,335 per recipient. We are therefore increasing the D prime by that amount. The base total is \$16,423. This amount will be inflated by 3.5%, the estimated amount of increase for rate increases per year based on historical trends.

- 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 G factor is a blended rate of nursing facility rates. The first number is based on the current average for nursing facility services for those individuals eligible for regular Elderly and Disabled services. The second number for the TBI group is based on the nursing facility rate for the facility in North Dakota that serves this population. The third number for the ventilator dependent group is based on the highest rate in the highest cost nursing facility in North Dakota. The rates were blended by multiplying the rates by the estimated number of waiver recipients in each of these groups. The totals were then divided by the total number of recipients to arrive at the blended amount. This amount was then inflated by 5% per year, which is the historical cost increase for nursing facilities in North Dakota.

- 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:

The latest 372 report indicated that the average cost of other services for individuals residing in nursing facilities was \$4,308. This figure included the cost of Part D Medicare prescription drugs. Based on a report we obtained from historical data the average reduction in yearly costs for individuals on Part D Medicare was \$2,838 per year. Based on that information we concluded that G prime costs for the Medicaid program totaled only \$1,470 per year. This figure is inflated by 3.5% per year based on historical cost increases for the non-nursing facility costs.

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
Case Management
Homemaker
Adult Day Care
Adult Residential Care
Transitional Living
Supported Employment
Respite Care
Chore
Emergency Response
Environmental Modification
Non-Medical Transportation
Adult Family Foster Care
Specialized Equipment & Supplies
Attendant Care Service

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
Case Management Total:						168960.00
Case Management	Monthly	400	4.00	105.60	168960.00	
Homemaker Total:						147256.00
Homemaker	15 min.	100	466.00	3.16	147256.00	
Adult Day Care Total:						3720.36
Adult Day Care	1/2 day	2	86.00	21.63	3720.36	
Adult Residential Care Total:						1268311.20
Adult Residential Care	Daily	53	260.00	92.04	1268311.20	
Transitional Living Total:						126326.20
Transitional Living	Daily	10	286.00	44.17	126326.20	
Supported Employment Total:						1991.72
Supported Employment	15 min.	2	202.00	4.93	1991.72	
Respite Care Total:						249237.00
Respite Care	15 min.	90	905.00	3.06	249237.00	
Chore Total:						5740.00
Chore	15 min.	40	50.00	2.87	5740.00	
Emergency Response Total:						36075.00
Emergency Response	Monthly	130	10.00	27.75	36075.00	
Environmental Modification Total:						16000.00
Environmental Modification	Per Job	4	1.00	4000.00	16000.00	
Non-Medical Transportation Total:						19372.50
Non-Medical Transportation	Trip	50	189.00	2.05	19372.50	
Adult Family Foster Care Total:						286638.00

Adult Family Foster Care	Daily	22	258.00	50.50	286638.00	
Specialized Equipment & Supplies Total:						2500.00
Specialized Equipment & Supplies	Per Item	5	1.00	500.00	2500.00	
Attendant Care Service Total:						365217.60
Nurse Management	15 min.	3	800.00	10.70	25680.00	
Attendant Care Service	15 min	3	35040.00	3.23	339537.60	
GRAND TOTAL:					2697345.58	
Total Estimated Unduplicated Participants:					400	
Factor D (Divide total by number of participants):					6743.36	
Average Length of Stay on the Waiver:					276	

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
Case Management Total:						186684.40
Case Management	Monthly	427	4.00	109.30	186684.40	
Homemaker Total:						164798.19
Homemaker	15 min.	107	471.00	3.27	164798.19	
Adult Day Care Total:						3894.12
Adult Day Care	1/2 day	2	87.00	22.38	3894.12	
Adult Residential Care Total:						1337450.40
Adult Residential Care	Daily	54	260.00	95.26	1337450.40	
Transitional Living Total:						143835.12
Transitional Living	Daily	11	286.00	45.72	143835.12	
Supported Employment Total:						2080.80
Supported Employment	15 min.	2	204.00	5.10	2080.80	

Respite Care Total:						278148.48
Respite Care	15 min.	96	914.00	3.17	278148.48	
Chore Total:						6513.21
Chore	15 min.	43	51.00	2.97	6513.21	
Emergency Response Total:						39920.80
Emergency Response	Monthly	139	10.00	28.72	39920.80	
Environmental Modification Total:						16560.00
Environmental Modification	Per Job	4	1.00	4140.00	16560.00	
Non-Medical Transportation Total:						21460.76
Non-Medical Transportation	Trip	53	191.00	2.12	21460.76	
Adult Family Foster Care Total:						323655.84
Adult Family Foster Care	Daily	24	258.00	52.27	323655.84	
Specialized Equipment & Supplies Total:						3108.00
Specialized Equipment & Supplies	Per Item	6	1.00	518.00	3108.00	
Attendant Care Service Total:						377934.48
Nurse Management	15 min.	3	808.00	11.07	26833.68	
Attendant Care Service	15 min.	3	35040.00	3.34	351100.80	
GRAND TOTAL:						2906044.60
Total Estimated Unduplicated Participants:						427
Factor D (Divide total by number of participants):						6805.73
Average Length of Stay on the Waiver:						276

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
Case Management Total:						205444.08

Case Management	Monthly	454	4.00	113.13	205444.08	
Homemaker Total:						185021.20
Homemaker	15 min.	115	476.00	3.38	185021.20	
Adult Day Care Total:						4076.16
Adult Day Care	1/2 day	2	88.00	23.16	4076.16	
Adult Residential Care Total:						1409837.00
Adult Residential Care	Daily	55	260.00	98.59	1409837.00	
Transitional Living Total:						162402.24
Transitional Living	Daily	12	286.00	47.32	162402.24	
Supported Employment Total:						2175.36
Supported Employment	15 min.	2	206.00	5.28	2175.36	
Respite Care Total:						311826.32
Respite Care	15 min.	103	923.00	3.28	311826.32	
Chore Total:						7343.44
Chore	15 min.	46	52.00	3.07	7343.44	
Emergency Response Total:						44297.70
Emergency Response	Monthly	149	10.00	29.73	44297.70	
Environmental Modification Total:						17140.00
Environmental Modification	Per Job	4	1.00	4285.00	17140.00	
Non-Medical Transportation Total:						24092.19
Non-Medical Transportation	Trip	57	193.00	2.19	24092.19	
Adult Family Foster Care Total:						362902.80
Adult Family Foster Care	Daily	26	258.00	54.10	362902.80	
Specialized Equipment & Supplies Total:						3752.00
Specialized Equipment & Supplies	Per Item	7	1.00	536.00	3752.00	
Attendant Care Service Total:						391769.28
Nurse Management	15 min.	3	816.00	11.46	28054.08	
Attendant Care Service	15 min	3	35040.00	3.46	363715.20	
GRAND TOTAL:					3132079.77	
Total Estimated Unduplicated Participants:					454	
Factor D (Divide total by number of participants):					6898.85	

Average Length of Stay on the Waiver:

276

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 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						281601.45
Case Management	Monthly	481	5.00	117.09	281601.45	
Homemaker Total:						207070.50
Homemaker	15 min.	123	481.00	3.50	207070.50	
Adult Day Care Total:						6399.99
Adult Day Care	1/2 day	3	89.00	23.97	6399.99	
Adult Residential Care Total:						1485702.40
Adult Residential Care	Daily	56	260.00	102.04	1485702.40	
Transitional Living Total:						182107.64
Transitional Living	Daily	13	286.00	48.98	182107.64	
Supported Employment Total:						3407.04
Supported Employment	15 min.	3	208.00	5.46	3407.04	
Respite Care Total:						347542.80
Respite Care	15 min.	110	932.00	3.39	347542.80	
Chore Total:						8258.46
Chore	15 min.	49	53.00	3.18	8258.46	
Emergency Response Total:						48924.30
Emergency Response	Monthly	159	10.00	30.77	48924.30	
Environmental Modification Total:						17740.00
Environmental Modification	Per Job	4	1.00	4435.00	17740.00	
Non-Medical Transportation						

Total:						27001.65
Non-Medical Transportation	Trip	61	195.00	2.27	27001.65	
Adult Family Foster Care Total:						404471.76
Adult Family Foster Care	Daily	28	258.00	55.99	404471.76	
Specialized Equipment & Supplies Total:						4440.00
Specialized Equipment & Supplies	Per Item	8	1.00	555.00	4440.00	
Attendant Care Service Total:						405647.52
Nurse Management	15 min.	3	824.00	11.86	29317.92	
Attendant Care Service	15 min	3	35040.00	3.58	376329.60	
GRAND TOTAL:						3430315.51
Total Estimated Unduplicated Participants:						481
Factor D (Divide total by number of participants):						7131.63
Average Length of Stay on the Waiver:						276

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 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						307822.60
Case Management	Monthly	508	5.00	121.19	307822.60	
Homemaker Total:						232230.24
Homemaker	15 min.	132	486.00	3.62	232230.24	
Adult Day Care Total:						6698.70
Adult Day Care	1/2 day	3	90.00	24.81	6698.70	
Adult Residential Care Total:						1565140.20
Adult Residential Care	Daily	57	260.00	105.61	1565140.20	
Transitional Living Total:						202962.76

Transitional Living	Daily	14	286.00	50.69	202962.76	
Supported Employment Total:						3559.50
Supported Employment	15 min.	3	210.00	5.65	3559.50	
Respite Care Total:						389743.38
Respite Care	15 min.	118	941.00	3.51	389743.38	
Chore Total:						9238.32
Chore	15 min.	52	54.00	3.29	9238.32	
Emergency Response Total:						54145.00
Emergency Response	Monthly	170	10.00	31.85	54145.00	
Environmental Modification Total:						18360.00
Environmental Modification	Per Job	4	1.00	4590.00	18360.00	
Non-Medical Transportation Total:						30091.75
Non-Medical Transportation	Trip	65	197.00	2.35	30091.75	
Adult Family Foster Care Total:						448533.00
Adult Family Foster Care	Daily	30	258.00	57.95	448533.00	
Specialized Equipment & Supplies Total:						5175.00
Specialized Equipment & Supplies	Per Item	9	1.00	575.00	5175.00	
Attendant Care Service Total:						420646.08
Nurse Management	15 min.	3	832.00	12.28	30650.88	
Attendant Care Service	15 min	3	35040.00	3.71	389995.20	
GRAND TOTAL:					3694346.53	
Total Estimated Unduplicated Participants:					508	
Factor D (Divide total by number of participants):					7272.34	
Average Length of Stay on the Waiver:						276