

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

### 1. Request Information

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

B. Program Title:

Autism Spectrum Disorder (ASD) Birth through Seven

C. Waiver Number: ND.0842

D. Amendment Number:

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

06/01/14

Approved Effective Date of Waiver being Amended: 11/01/13

### 2. Purpose(s) of Amendment

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

The Department of Human Services, under state legislative direction, seeks to expand its autism waiver program.

In accordance with these instructions, the following information has been changed in these appendices:

APPENDIX A: The administration has changed from the Developmental Disabilities Division to the Autism Services Unit

APPENDIX B: Covering seventeen (17) additional individuals served, from the current 30 participants to a total of 47

individuals served, and expanding the ages served from birth through four (4) years to birth through seven (7) years

APPENDIX C: Service changes to a more autism-specific focus; from In-Home Supports to Respite Care, from Intervention

Coordination to Program Design & Monitoring and Skills Training, from equipment & supplies and home monitoring to

Assistive Tech, and from Developmental Disabilities Program Management to Service Management

APPENDIX D: The use of the Vineland II assessment as a more autism-specific level of care (LoC) tool in replacement of the Progress Assessment Review (PAR)

APPENDIX E: Self direction opportunities for in-home supports will be changed to allow families to choose between self-direction or agency-provided respite care

APPENDIX F: Changes in language from oversight by Developmental Disabilities Division to Oversight by the Autism Services Unit

APPENDIX G: Addition of tracking/reporting of elopement attempts by waiver participants

APPENDIX H: Updated to reflect changes in performance measures

APPENDIX I: Updated to reflect changes in services

APPENDIX J: Adjustments to the budget to accommodate the additional 17 waiver slots for a total of 47 individuals served

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**3. Nature of the Amendment**

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

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input checked="" type="checkbox"/> Appendix C – Participant Services	
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

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

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Changes in ages from birth- age 4 to birth-age 7

**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*):  
**Autism Spectrum Disorder (ASD) Birth through Seven**

**C. Type of Request:** amendment

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

- 3 years
- 5 years

**Draft ID:** ND.12.01.02

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 11/01/13

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Approved Effective Date of Waiver being Amended: 11/01/13

## 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

**Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

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

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

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

The State additionally limits the waiver to individuals, birth through seven, with a diagnosis of autism spectrum disorder (ASD) as determined within the most current DSM. The evaluation and diagnostic teams (EDT) consists of professionals with advanced training in Autism Spectrum Disorder issues related to children birth through seven. The teams determines or confirms diagnosis of ASD based on multidisciplinary evaluations. As appropriate, an EDT member is available to review data to determine if the participant is making progress or if the local team needs to define the implementation strategies.

## 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)(1)(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)

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- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.  
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:  
\_\_\_\_\_
- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.  
Specify the program:  
\_\_\_\_\_

#### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

## 2. Brief Waiver Description

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

The North Dakota Autism Spectrum Disorder (ASD) birth through seven (age 7) waiver provides service options for individuals living with a primary caregiver. The goal of the waiver is to support the primary caregiver to maximizing the child's development and preventing out of home placements.

The objectives include:

1. A state EDT validates a diagnosis or establishes the child's diagnosis for placement on the waiver and provides recommendations to a local team that includes the family,
2. Service Management to assist in the implementation of the participant service plan,
3. Program and Design Monitoring to develop intensive behavioral intervention strategies,
4. Skills Training to implement the intensive behavioral intervention strategies,
5. to provide respite care to support families, and
6. assistive technology.

The Service Manager (SM), assists in gaining access to needed medical, social, educational, and other resources and supports. Families have the option to self-direct or choose provider directed respite supports and vendors supply assistive technology with the assistance of a fiscal agent.

Participant Directed services are reimbursed at the usual and customary rate up to the individual budget limit. Payment rates are noted on the participant authorization that the SM reviews with the family prior to each authorization period. All services are authorized by an individual authorization.

The state oversees the process from application to delivery of service including child outcomes.

## 3. Components of the Waiver Request

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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.

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- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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- 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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewide 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:*

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- Limited Implementation of Participant-Direction.** A waiver of statewide 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:*
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## 5. Assurances

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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.

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- 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

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §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 Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery,

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remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

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

The North Dakota Department of Human Services sent letters of intent to the recognized tribes in North Dakota and public comments were accepted for 60 days. In addition, the ASD taskforce held meetings on 2/2/2012, 5/12/2012, 9/7/2012, 1/3/2013, 07/22/2013, 09/11/2013, 12/16/2013 and collected information on recommendations for waiver services. Each taskforce meeting included statewide video conferencing sites where the public presented their thoughts and views on autism services. Two public informational meetings were held 12/17/2013 and 12/19/2013 via video conferencing in all eight (8) regional locations to provide information on the waiver changes and gather input. A legislative ASD study during the 2011-2012 interim resulted in legislation passed in the 2013 legislative session resulting in the waiver expansion. The Medicaid advisory committee was held on Nov. 21, 2013 and an autism panel was held by Family Voices of ND, an advocacy organization, in October 2013. Monthly meetings were held with North Dakota Center for Persons with Disability at Minot State University on the Support Autism North Dakota grant.

**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)**

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

**Last Name:** \_\_\_\_\_  
Page

**First Name:** \_\_\_\_\_  
Trisha

**Title:** \_\_\_\_\_  
State Autism Coordinator

**Agency:** \_\_\_\_\_  
Autism Services Unit

**Address:** \_\_\_\_\_  
1237 W Divide Ave

**Address 2:** \_\_\_\_\_  
Suite 1A

**City:** \_\_\_\_\_  
Bismarck

**State:** \_\_\_\_\_  
North Dakota

**Zip:** \_\_\_\_\_  
58501-1208

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Phone: (701) 328-8949 Ext:  TTY

Fax: (701) 328-8969

E-mail: tpage@nd.gov

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

Last Name: Hoesel

First Name: JoAnne

Title: Program and Policy Lead

Agency: Department of Human Services

Address: 1237 West Divide Ave.

Address 2: Suite 1C

City: Bismarck

State: North Dakota

Zip: 58501-1208

Phone: (701) 328-8924 Ext:  TTY

Fax: (701) 328-8969

E-mail: jhoesel@nd.gov

**8. Authorizing Signature**

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

Signature: \_\_\_\_\_

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State Medicaid Director or Designee

Submission Date: \_\_\_\_\_

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

Last Name: \_\_\_\_\_  
Schwab

First Name: \_\_\_\_\_  
Julie

Title: \_\_\_\_\_  
Medicaid Director

Agency: \_\_\_\_\_  
Medical Services Division

Address: \_\_\_\_\_  
600 East Blvd. Ave. #325

Address 2: \_\_\_\_\_

City: \_\_\_\_\_  
Bismarck

State: \_\_\_\_\_  
North Dakota

Zip: \_\_\_\_\_  
58505

Phone: \_\_\_\_\_  
(701) 328-1603 Ext:  TTY

Fax: \_\_\_\_\_  
(701) 328-1544

E-mail: \_\_\_\_\_  
Attachment #1: jfschwab@nd.gov

**Transition Plan**

Specify the transition plan for the waiver:

- 1.) Participants currently served on the current waiver and will continue on the amended waiver- Developmental Disability Program Managers (DDPM) will be provided with a script and information packet that describes the new services, services manager choices, and will develop a transition plan with the legal guardian and participant.
- 2.) Participants currently on the waiver that will not continue on the amended waiver- DDPMs will be provided a script and information packet and if legal guardian chooses not to continue with amended waiver, the legal guardian will be made aware of other service options.
- 3.) Participants that turn eight years old and age out of the amended waiver- Service managers will discuss other service options available to families prior to their eighth birthday.

**Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

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

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

#### Direct Impact:

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

#### Consultation:

When it is determined that a proposal or change would have a direct impact on North Dakota Tribes, Indian Health Services or American Indians, the North Dakota Department of Human Services will issue written correspondence via standard mail and email to Tribal

Chairs, Tribal Healthcare Directors, the Executive Director of the Indian Affairs Commission, Indian Health Services Representatives and the Executive Director of the Great Plains Tribal Chairmen's Health Board. In addition to the written correspondence, the Department may use one or more of the following methods to provide notice or request input from the North Dakota Indian Tribes and IHS.

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

#### Ongoing Correspondence:

- A web link will be located on the North Dakota Department of Human Services website specific to the North Dakota Tribes. Information contained on this link will include: notices described below, proposed and final State Plan amendments, frequently asked questions and other applicable documents.
- A specific contact at the North Dakota Department of Human Services Medical Services Division, in addition to the Medicaid Director, will be assigned for all ongoing Tribal needs. This contact information will be disseminated in the continuing correspondence with the North Dakota Tribes.

Content of the written correspondence will include:

- Purpose of the proposal/change
- Effective date of change
- Anticipated impact on Tribal population and programs
- Location, Date and Time of Face to Face Consultation OR If Consultation is by Written Correspondence, the Method for providing comments and a timeframe for responses. Responses to written correspondence are due to the Department 30 days after receipt of the written notice.

#### Meeting Requests:

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

## **Appendix A: Waiver Administration and Operation**

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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.

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

**Autism Services Unit**

*(Complete item A-2-a).*

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

Specify the division/unit name:

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

## **Appendix A: Waiver Administration and Operation**

### **2. Oversight of Performance.**

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

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

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

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

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## Appendix A: Waiver Administration and Operation

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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.*

A contract with a Fiscal Agent to support self-directed activities through the ASD waiver is in place.

**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

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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:*

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**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:*

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## Appendix A: Waiver Administration and Operation

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

The ND Department of Human Services (Department), Autism Services Unit, will monitor the Fiscal Agent contract per Department contract oversight protocol.

## Appendix A: Waiver Administration and Operation

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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:

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Fiscal Agent activities are continually monitored by families, SMS, and the state through on-line individual balance sheet reports. Feedback is solicited from staff working with the Fiscal Agent to measure satisfaction with the current contractor. The Department of Human Services also monitors monthly contract billings.

The Fiscal Agent contract is monitored by routine calls with the Autism Services Unit staff, monthly reports will be sent to the service managers and families.

The contract is monitored at least every 6 months following the Department of Human Services contract oversight procedures.

The family's satisfaction with the contractor is addressed at each participant's service plan meeting, which is reviewed quarterly.

**Appendix A: Waiver Administration and Operation**

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

(A-1) Number and percent of self-directed services, correctly paid by the fiscal agent, that are authorized on the participant's authorization. N: The number of authorized services, correctly paid for by the fiscal agent, that are on the authorization. D: All self-directed services paid by the fiscal agent.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Report from fiscal agent**

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

**Data Aggregation and Analysis:**

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

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon discovery the fiscal agent contacts the service manager for any services not on authorization. The services manager works with the family to resolve the issue. Issues and solutions are documented in web-based data system by the service manager. Services manager communicates resolution to the fiscal agent.

The service managers are responsible for addressing individual problems; if resolution cannot be found, the service manager contacts the state autism coordinator for resolution. The state maintains documentation that tracks training, policy changes, recouped funds and terminations.

**ii. Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

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

**Appendix B: Participant Access and Eligibility**

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

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to 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"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<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 checked="" type="radio"/> <b>Intellectual Disability or Developmental Disability, or Both</b>					
	<input checked="" type="checkbox"/>	Autism	0	7	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="radio"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

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The state limits this waiver to individuals on the Autism Spectrum as diagnosed/concurred by teams identified by the state (Evaluation and Diagnostic Teams - EDT). The state further limits this waiver to families that agree to self-direct assistive technology.

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

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

*Specify:*

Families are made aware of the maximum age limit and duration upon enrollment. The service manager coordinates with the Part B of (IDEA) Individuals with Disabilities Education Act to facilitate their participation in school and by the participant's seventh birthday makes the family aware of other support options including the traditional DD waiver, state plan services, Buy-In Program, CHIPS, and other informal supports available within their communities. One year prior to the child exiting this waiver, their participant service plan contains a transition of outcomes and activities.

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage: \_\_\_\_\_

- Other

*Specify:*

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

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

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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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

**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:

**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)

DRAFT

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	47
Year 2	47
Year 3	47
Year 4	47
Year 5	47

- 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	
Year 5	

**Appendix B: Participant Access and Eligibility**

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

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- 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:

Until the waiver cap is reached, the eligible families are enrolled on a first-come, first-served basis. When the cap is reached, a waiting list is established based on time of waiver slot request.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

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

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

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

- No  
 Yes

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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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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 in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

All other mandatory and optional groups covered under North Dakota State Plan.

**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:

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- 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.

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**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 and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-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-6: Evaluation/Reevaluation of Level of Care**

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

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*Specify the entity:*

**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:

The minimum qualifications for the State Autism Coordinator are Bachelor Degree in Human Service area, 4 years of experience with autism, public speaking, consensus building, and autism certificate preferred.

- 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 child diagnosed with autism spectrum disorder using the most current DSM criteria must have significant deficits in adaptive behaviors based on Vineland II Survey Interview domain scores, or deficits in adaptive behaviors coupled with maladaptive behaviors. These criteria are further defined as follows: A score of 70 or less in any one of the following Vineland II domains (Communication, Daily Living Skills, Socialization), plus an Adaptive Behavior Composite score of 70 or less.

Scores above 70 that fall within the confidence interval of the Vineland II, based on the developmental age of the child, will not preclude a child's eligibility for the waiver. For example, a child diagnosed with ASD with a score of 74 for the Communication Domain, coupled with an Adaptive Behavior Composite score of 72, and the confidence interval is 5 points for the child's developmental age would be considered eligible for the Waiver.

A Maladaptive Behavior Index Score between 21 and 24 indicates the presence of significant behavioral challenges. Children with a Maladaptive Behavior Index Score in this range are considered eligible for the waiver, if the child also has Vineland II Domain scores for two of the three adaptive behavior domains (Communication, Daily Living Skills, Socialization) of 85 or less. Scores falling within the range of the test confidence interval for the child's developmental age in this case will also qualify a child as eligible for the waiver.

- 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 initial step in the level of care process is to establish if the waiver applicant has a qualifying diagnosis of ASD and the child has significantly delayed adaptive functioning in activities in daily living, socialization, or communication as described in Appendix B-6-d. Alternatively, children with a qualifying diagnosis of ASD and moderate delays in adaptive behavior functioning coupled with a clinically significant maladaptive behavior index

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scores will generally qualify for autism waiver services as described in Appendix B-6-d.

Through a contract with the Autism Services Unit, the EDT is responsible for establishing if an applicant is initially eligible for services based on qualifying diagnoses. A two-stage intake screening process will occur. A generic description of this process follows:

A telephone call or face-to-face interview is held between the state autism coordinator and a parent. Standardized questions related to ASD behavioral indicators are asked. If the parental responses indicate the need for testing and evaluation, releases of information will be obtained and a referral is made to the EDT.

The level of care criteria used for the re-evaluation is the same criteria applied for the initial level of care. The EDT completes the evaluation based on the most current assessment information available and an interview with the individual and/or those who know the person best. The re-evaluation does not require an updated psychological assessment if the diagnosis has been confirmed, unless it is determined that a new assessment is beneficial or is needed.

- 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*):

Service managers are responsible to retain a schedule of when reevaluations are due and to schedule and ensure that the EDTeam completes the LoC tool in a timely manner.

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

Documentation of the Level of Care Evaluations/Reevaluations is maintained electronically in the autism services unit for each individual for a minimum of 3 years. The MMIS system also maintains a record/history of level of care determinations.

## **Appendix B: Evaluation/Reevaluation of Level of Care**

### **Quality Improvement: Level of Care**

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

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

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of new waiver enrollees who had an initial Level of Care. N;**  
**Number of new waiver enrollees who had a LoC prior to receiving services. D: All new enrollees.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Query of data from web based computer system database.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

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<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of waiver participants who have an accurately completed initial LoC determination. N: Waiver participants who have an accurately completed LoC determination. D: Sample of waiver participants reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Manual Level of Care Integrity Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

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	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

DRAFT

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Patterns of errors are analyzed quarterly to determine if they are the result of individual or systemic issues. The state autism coordinator addresses individual and systemic issues.

**ii. Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

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- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

Participants eligible for the waiver are provided with a choice of institutional or HCBS services, feasible alternatives under available waivers are explained by the Service Managers and a description of roles and responsibilities regarding Self Directing are provided to the participant and legal guardian. The guardian's choice is documented on the Participant Service Plan. This information is provided at the time of waiver eligibility determination and annually thereafter.

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

The signed participant service plan is maintained in the family's file at the autism services unit following the Department's retention policy.

**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):

The services of an interpreter are arranged when a participant and/or their legal guardian is unable to independently communicate with the state autism coordinator. Written material may also be modified for non-English speaking participants. The North Dakota Department of Human Services has a Limited English Proficiency Implementation Plan to assist staff in communicating with all participants.

**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	Respite		
Statutory Service	Service Management		
Other Service	Assistive Technology		

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Service Type	Service		
Other Service	Program Design and Monitoring		
Other Service	Skills Training		

**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):**

---

**Service Definition (Scope):**

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the need for relief of the primary caregivers. Routine respite care may include hourly, daily and overnight support and may be provided in the individual’s place of residence, a facility approved by the State which is not a private residence, or in the private residence of the respite care provider.

These services are selected in collaboration with the parents and are provided by persons chosen and trained by the family or through a provider directed service. Persons providing respite services will be in compliance with all State and federal respite standards. Respite Services including amount and frequency of respite care (with the exception of emergencies) are delivered in conformity with an participant’s service plan.

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

Respite is only available to primary caregivers in family settings. Payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid.

Respite care shall not be used as day/child care to allow the persons normally providing care to go to work or school. Respite care cannot be used to provide service to a participant while the participant is eligible to receive Part B services and could otherwise gain support through the Department of Public Instruction.

Based upon the level of support need Respite is limited, per participant, to 20, 40, or 60 hours of service 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	Individual
Agency	Agency

DRAFT

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Individual ▾

**Provider Type:**

Individual

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

Providers of services must be over the age of 18, cannot live in the participant's home, and must pass background check requirements as identified by the state. Providers of services must also meet the criteria identified in the participant's service plan.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Agent and Service Manager

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency ▾

**Provider Type:**

Agency

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

Providers of services must be over the age of 18, cannot live in the participant's home, and must pass background check requirements as identified by the state. Providers of services must also meet the criteria identified in the participant's service plan.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Autism Services Unit

**Frequency of Verification:**

Annually

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**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):**

Service Management

**Service Definition (Scope):**

The service manager will assist participants in gaining access to waiver and other state plan services as well as medical, social, educational, and other services regardless of the funding source for the services to which access is gained.

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

Based upon the the Level of Care need, the amount of service management hours cannot exceed an average of 6 hours per week.

Service management is a required service to participate in this waiver.

**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 or agency

**Appendix C: Participant Services**

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

Service Type: Statutory Service

Service Name: Service Management

**Provider Category:**

Individual

**Provider Type:**

Individual or agency

**Provider Qualifications**

License (specify):

Certificate (specify):

DRAFT

**Other Standard (specify):**

Service Managers must have a bachelor's degree in social work, psychology, occupational therapy, physical therapy, child development and family science, communication disorders (includes audiology or speech pathology), special education, sociology, elementary education and two years of experience working with children with autism or related conditions, or

A master's degree in counseling or psychology or a doctorate in medicine will also meet requirements.

And a certification or other national or state designation of expertise in Autism is required and if all other qualifications above are met, each service manager provided by the contracted agency will have obtained a certification prior to first contract renewal.

Or

Five year's experience working with children with conditions on the autism spectrum or related conditions and/or their families, if all other qualifications are met above.

And a certification or other national or state designation of expertise in autism is required and if all other qualifications above are met, each service manager provided by the contracted agency will have obtained a certification prior to first contract renewal.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Autism Services Unit

**Frequency of Verification:**

Annually

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

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

**Service Type:**

Other Service

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

**Service Title:**

Assistive Technology

**Service Definition (Scope):**

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, as specified in the plan of care that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. A recommendation from an appropriate professional, documenting three (3) separate successful trials is required.

Assistive technology includes:

- a) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- b) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participant;
- c) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or

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- replacing assistive technology devices;
- d) Training or technical assistance for the participant, or, where appropriate, the family members, or authorized representatives of the participant; and
- e) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the participant.
- f) Assistive Technology must be consistent with the participant's behavioral support plan.
- g) Monthly Fee is a periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with devices, controls, or appliances, specified in the individual support plan, which 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.
- h) Extended warranties

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

Items available under the participant's private health insurance are excluded.

Up to \$5,200 per participant for the duration of the waiver is the limit for Assistive Technology unless an exception is granted by state autism coordinator as preventing imminent institutionalization.

Items reimbursed with Waiver funds do not include any assistive technology furnished by the school program for both home and school use or by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Items shall be specific to a participant's individual needs, documented in the participant's service plan, and not be approved to benefit the public at large, staff, significant others, or family members.

**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	Vendor

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Assistive Technology**

**Provider Category:**

Agency

**Provider Type:**

Vendor

**Provider Qualifications**

**License (specify):**

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**Certificate (specify):**

DRAFT

**Other Standard (specify):**

Families and their service managers identify appropriate assistive technology within the participant's service plan. The legal decision maker will obtain the assistive technology supplies from a vendor who is enrolled with the Fiscal Agent and registered with the Secretary of State. The vendor must provide the item approved in the Participant Service Plan and selected by the family as cost effective.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Service Managers and the Autism Services Unit

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Program Design and Monitoring

**Service Definition (Scope):**

Develops individualized formal written training plans and protocols using evidence based training approaches. Provides training to the Skills Trainer in the individualized plans.

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

Fiscal limits of a one-time annual fee for services contract for the year, including an initial Behavioral Assessment, any needed family interviews or follow-up program modifications, and implementation of the program through the Skills Trainer.

**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**

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**Service Type: Other Service**  
**Service Name: Program Design and Monitoring**

---

**Provider Category:**

Agency ▾

**Provider Type:**

Agency

**Provider Qualifications****License (specify):**

Licensed ND Psychologist OR licensed applied behavior analyst

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

Registered applied behavior analyst, or person pursuing a course of study in psychology, or applied behavior analysis at a school or college, if the activities and services are a part of the individual's supervised course of study and are under the supervision of a licensed psychologist, or applied behavior analyst.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Service Managers and the Autism Services Unit

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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### 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:**

Skills Training

**Service Definition (Scope):**

Skills Training is a direct service designed to assist participants in acquiring, retaining and generalizing the self-help, socialization, cognitive, communication, organizational skills and the positive behaviors necessary to function successfully in home and community settings. The Skills Training (ST) occur where the participant lives, attends childcare and/or socializes with peers. The bulk of the ST is likely to occur in the participant's home. It is expected that Skills Training may be delivered in group settings with same-age peers or in one-to-one settings based on the assessed needs of the participant, however the expectation is that the majority of Skills Training will be delivered in one-to-one settings. If group settings are going to be utilized, documentation of purpose must be evident in the participant service plan.

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

A goal set for a minimum of 20 hours Skills Training per week per participant is delivered.

**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):

DRAFT

- 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: Skills Training**

**Provider Category:**

Agency ▾

**Provider Type:**

agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Requires a bachelor's degree in social work, psychology, counseling, nursing, occupational therapy, physical therapy, child development, communication disorders (includes audiology and speech pathology), special education, sociology, elementary education, recreation therapy and two years of experience working with special population groups in a direct care setting, or a master's degree in one of the fields listed.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Service Manager and the Autism Services Unit

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

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

*Check each that applies:*

- As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- 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.

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- 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

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### 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):

As provided by NDAC and Autism Services division policy, criminal background checks must be conducted on all prospective contractors who may have access to individuals served. When prospective employees have lived in North Dakota for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.

Employees hired by families for Respite care have background checks completed by the Fiscal Agent.

Upon annual application for contract renewal, the agency submits a listing of each current employee with any new criminal convictions, the date of conviction, and the nature of the offence. If the offence is a direct bearing offence, the appropriate contractee or family is notified by the state autism coordinator that the employee cannot provide services to the participant.

- 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):

Autism Services policy also requires that providers conduct a check of the Child Abuse and Neglect Registry for each employee hired. The Child Abuse and Neglect Registry are maintained by the ND Department of Human Services Children and Family Services Division. An abuse registry is not maintained specifically for providers of waiver services.

## Appendix C: Participant Services

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

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

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**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).**

## 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 who are not legal guardians and not living in the same home as the eligible consumer may be paid for providing waiver services if they meet all other requirements.

**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.

**Other policy.**

**DRAFT**

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:

Anyone who meets the requirements identified in the Participant Service Plan and provider qualifications listed by service may be hired by the family.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

#### a. Methods for Discovery: Qualified Providers

##### i. Sub-Assurances:

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

#### Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

#### Performance Measure:

(C-1) Number and percent of providers subject to certification and adherence to other standards prior to furnishing waiver services. N: Number of providers who meet certification standards and adhered to ND State laws prior to furnishing waiver services. D: All provider applicants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

#### Provider Data Base

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

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		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information*

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on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

(C-2) Number and percent of new self-directed service Respite employees who have met ND state laws and standards. N: All new self-directed service Respite employees that have met ND state laws and standards. D: All new self-directed service Respite employees.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Report from Fiscal Agent**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Semi-annually (every 6 months)	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

DRAFT

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

(C-3) Number and percent of provider agencies, whose staff complete State required training. N: Number of provider agencies, whose staff completed State required training. D: All provider agencies.

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

DRAFT

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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



**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
When deficiencies are discovered, specific plans of correction are required in order to maintain ND state laws and standards.

**ii. Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

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

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

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

**Appendix C: Participant Services**

**C-4: Additional Limits on Amount of Waiver Services**

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

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

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

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

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- 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.*

- 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:  
Participant Service Plan

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

**DRAFT**

**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:*

**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.

The SM informs the participant and family of their right to be involved in the development of the Participant Service Plan, and their right to choose who can be involved in the assessment and program plan development. The participant and their family also are given the opportunity to choose the time and location of meetings, and the makeup of team membership.

**Appendix D: Participant-Centered Planning and Service Delivery****D-1: Service Plan Development (4 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):

The EDT completes the Vineland II at the time of assessment to help identify the individual's specific areas of strengths and needs. The Service Manager (SM) initiates the service plan development at the time of enrollment with the family. A Risk Assessment checklist is also completed with the family to identify potential risks to the individual and how the risks are currently being addressed. The SM assists the family in identifying outcomes (what is important to the individual, what it is they want and why) and also informs the family of Medicaid funded services that may assist them in achieving their identified outcomes and assist in the referral and access to services. The SM explains and provides written information to the family regarding institutional vs. home and community based services; waiver options; and roles and responsibilities of self-directing supports. The SM documents the individual's identified outcomes and requested services in the Participant Service Plan. The Participant Service Plan also includes other services, including the amount and frequency, and other supports the individual is currently receiving, regardless of funding source. The family is given their choice of waiver services. If the individual is denied a choice of HCBS services, the family/legal guardian is informed of their opportunity to request a Fair Hearing.

A Participant Service Plan is developed before waiver services are authorized and at least annually thereafter (year minus one day). A Participant Service Plan Checklist describing the necessary components of the Participant Service Plan, is utilized statewide for the development of each waiver participant service plan. The checklist describes the

DRAFT

areas that need to be assessed and addressed in the Participant Service Plan, including health care needs and mitigation of identified risks. The Participant Service Plan is developed to identify the needs of the participant and to devise ways to meet those needs. The team includes the family, family members, friends or advocates chosen by the participant, and SM. Staff members who work most closely with the participant providing direct support and care, and know the participant best may also be invited to participate. The Participant Service Plan is finalized by the SM and when approved by the family, distributed to team members. The DDPM completes the preauthorization of home and community based services which are entered in the MMIS payment system for billing purposes. The following rights are printed on the Participant Service Plan and the signature of the family on the Participant Service Plan indicates that they have: a) received a copy of their rights and understand them; b) been informed of their right to request a change of SM; c) been informed of Protection and Advocacy Services; d) been informed of their right to select institutional services or waiver services (if the ICF/IID level of care is met); e) been informed of their right to a choice of service provider(s); f) received information regarding their right to appeal; g) are in agreement with the services listed on the Participant Service Plan; h) understand that for services requiring Title XIX funding, they must maintain Medicaid eligibility or private pay for those services.

The SM is responsible for in depth monitoring that will consist of a face to face visit with the waiver participant and a contact with the family every 90 days to review quality and satisfaction with services, to assure services are delivered as required and remain appropriate for the individual. In depth monitoring by the SM also includes review of individual records, monthly data collection relative to the plan, provider progress notes regarding significant events contained in the monthly update, review of incident reports from the quarter and verification that recommendations generated to prevent reoccurrence were implemented and effective. The SM shares the results and findings of the monitoring with the family and service provider(s) at the time of the Quality Enhancement Review (QER) visit. Identified areas of concern are addressed in an action plan developed by the service provider and SM. The results and findings of the in-depth monitoring are documented in the web based data system and are printed and distributed every 6 months.

The Participant Service Plan is updated at least annually (one year minus one day). The SM enters the information into the web-based database based on their annual assessment and submits this information to the State Autism Coordinator who responsible for final review and completed the ICF/IID Level of Care screen that is entered into the Medicaid payment system.

In addition, the plan is reviewed at least quarterly and updated if progress has not been made, towards measurable outcomes. The plan is also reviewed and updated when there is a significant change in the participant's needs due to change in the health or mental status of the participant; as goals and objectives are realized, or when a participant services change. The family and any team member can request a team meeting for plan revisions.

Prior to each annual plan, the SM reviews the rights information with the family, which includes their right to choose among and between waiver services, qualified providers and their right to appeal if they are denied the choice of services or provider.

## **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.

The SM completes the risk assessment with the family at the time of intake and initial waiver enrollment. Mitigation strategies are incorporated for each identified risk into the plan. The risk assessment is updated at least annually or whenever the status of the participant warrants a change in the plan to assure that all risks are identified and mitigation strategies are developed, documented, and implemented. The family is involved in the completion of the checklist and development of mitigation strategies during the plan development process and will have the opportunity to approve the plan, including risk prevention and mitigation activities prior to implementation of the plan. The risk assessment addresses the need to develop an effective, individualized back up plan to be incorporated into the plan.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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**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.

The SM shares information regarding local staff recruitment options and material specifically developed for self-directed supports. Participants and their legal decision makers are given a list of qualified providers of waived services upon waiver enrollment and prior to their Participant Service Plan, as well as on an as needed basis. SMs assist the participant, and their legal decision makers, in meeting with providers selected by the participant and their legal decision makers.

**Appendix D: Participant-Centered Planning and Service Delivery****D-1: Service Plan Development (7 of 8)**

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

The individually authorized services are by the Autism Services Unit, as identified in the Participant Service Plan and submitted by the SM.

The State Autism Coordinator serves as a representative of the Medicaid agency, as they are an employee of the Department of Human Services.

**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:*

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

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

*Specify:*

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**Appendix D: Participant-Centered Planning and Service Delivery****D-2: Service Plan Implementation and Monitoring**

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- 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 SM is responsible for monitoring the implementation of the Participant Service Plan and the health and welfare of the participant. The participant's family and SM prepare a specific plan describing the way in which services will be carried out. The family is responsible to oversee the day to day implementation of the plan, and access to non-waiver services including Health services.

The team reviews the Participant Service Plan quarterly. The SM is responsible for in depth monitoring that will consist of a face to face visit with the waiver participant and a contact with the family every 90 days to review quality and satisfaction with services, to assure services are delivered as required and remain appropriate for the individual. In depth monitoring by the SM will also include of review of individual records, monthly data collection relative to the plan, provider progress notes regarding significant events contained in the monthly update, review of incident reports from the quarter and verification that recommendations generated to prevent reoccurrence were implemented and effective. The SM will share the results and findings of the monitoring bi-annually with the family and service provider(s) at the time of the Participant Service Plan review visit. Identified areas of concern will be addressed in an action plan developed by the service providers and SM.

The Participant Service Plans are updated at least annually (one year minus one day). In addition, the plan will be reviewed at least quarterly and updated if progress has not been made, towards measurable outcomes. The plan reviews and updates when there is a significant change in the individual's needs due to change in the health or mental status of the individual; as goals and objectives are realized, or when an individual is moved from one setting to another or to another service. The family and any team member can request a team meeting for plan revisions.

Prior to each annual plan, the SM will review the rights information with the family, which includes their right to choose among and between waiver services, qualified providers and their right to appeal if they are denied the choice of services or provider.

- 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:*

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **Quality Improvement: Service Plan**

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

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

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

#### **Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**(D-1) Number and percent of Participant Service Plans (PSPs) that include strategies to address needs and mitigate risks identified through the assessment process. N: Number and percent of participant service plans that include strategies to address needs and mitigate risks identified through the assessment process. D: Total number of plans reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Secure electronic participant file**

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

**Data Aggregation and Analysis:**

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

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

- c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**(D-2) Number and percent of Participant Service Plans that are updated annually or reviewed/updated based on a participant's changing needs. N: Number of PSPs updated annually. D: Total number of PSPs reviewed.**

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**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Secure electronic data system**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

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<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	Specify: <input type="text"/>

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

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**(D-3) Number and percent of participants who receive the Skills Training as specified in their PSP. N: Number and percent of participants who receive the Skills Training as specified in their PSP. D: All participants.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Secure Electronic Data base**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

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	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**(D-4) Number and percent of participants who have a signed participant service plan which includes the ability to choose between/among waiver services and providers. N: Number and percent of participants who have a signed participant service plan which includes the ability to choose between/among waiver services and providers. D: All participant's reviewed.**

**Data Source (Select one):**  
**Other**

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If 'Other' is selected, specify:

**Secure electronic database**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
 The service manager is responsible to address unmitigated needs and assure that the participant service plan contains the requirements set forth by the State.

If further remediation is required beyond the service manager, the state autism coordinator includes a visit with the service manager, discussion with the participant's legal guardian(s), a record review of program implementation, verification of incident remediation and consumer satisfaction. Participant service plans are revised or modified as needed based on review.

**ii. Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No
- Yes

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

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## Appendix E: Participant Direction of Services

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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

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### E-1: Overview (1 of 13)

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

Self-directing opportunities are available in Respite and Assistive Technology. Participants determine the vendors/providers from whom they purchase services and supports. Participants have the opportunity to determine their priorities within the waiver budget limitations. SMs and the Fiscal Agent staff support participants as they self-direct. Information regarding risk and responsibility involved in self-direction, recommendations and considerations when selecting a vendor is provided in writing for participants and the material is reviewed with them. Guidance regarding key decisions and assistance in prioritizing needs is also offered.

## Appendix E: Participant Direction of Services

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### E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*
- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

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

Specify these living arrangements:

---

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

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

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

*Specify the criteria*

Self-directed services consist of respite and assistive technology. Assistive Technology will solely by participant directed and Respite can be either participant or provider directed.

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

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

Participants considering Participant Directed Services, upon enrollment and annually, SMs review written information with families regarding:

- Describes benefits and potential liabilities associated with participant direction of services;
- Responsibilities of participants;
- Support available through SMs and the Fiscal Agent;
- Component of a Participant Service Plan and their responsibility in its development;
- Information available on the Fiscal Agent's website.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

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

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- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

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

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

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

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3

The waiver service entitled:

- FMS are provided as an administrative activity.

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**Provide the following information**

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

Contract entity.

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

Monthly fee for service.

- iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

---

Supports furnished when the participant is the employer of direct support workers:

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- Assists participant in verifying support worker citizenship status
- Collects and processes timesheets of support workers
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other

*Specify:*

Payment to vendors for self-directed services

Provides background checks of Respite staff

---

Supports furnished when the participant exercises budget authority:

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- Maintains a separate account for each participant's participant-directed budget
- Tracks and reports participant funds, disbursements and the balance of participant funds
- Processes and pays invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

*Specify:*

Maintain a secure FTP that allows SMs & the Autism Services Unit to track participant's budget and expenditures.

---

Additional functions/activities:

---

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

*Specify:*

---

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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The performance of the Fiscal Agent is reviewed by the SM with the family during the quarterly meeting. Any concerns are documented in the web-based database that is forwarded to the Autism Services Unit, if the issue cannot be resolved by the SM and family.

The Autism Services Unit has frequent (at least every quarter) conference calls with the Fiscal Agent to review issues identified. The authorization process prevents over payment to the Fiscal Agent as the MMIS payment system has edits that prohibits payments in excess of authorized budget limits. The Autism Services Unit monitors monthly budget program spend down reports generated through MMIS payment system and monthly contract billings for Fiscal Agent services. As outlined in the contract with the Department, the Fiscal Agent has an independent audit conduct and shares the results.

**Appendix E: Participant Direction of Services**

**E-1: Overview (9 of 13)**

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Service Managers meet with the participants and their legal guardians to review the information regarding the roles, risks, and responsibilities involved with self-directing supports. The SMs connect with the fiscal agent, provide skills needed to self-direct, assist them in locating sources of waiver goods and services and developing budget management skills.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	<input type="checkbox"/>
Service Management	<input type="checkbox"/>
Program Design and Monitoring	<input type="checkbox"/>
Skills Training	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

**Appendix E: Participant Direction of Services**

**E-1: Overview (10 of 13)**

DRAFT

**k. Independent Advocacy** (*select one*).

- No. Arrangements have not been made for independent advocacy.
- Yes. Independent advocacy is available to participants who direct their services.

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

Participants are informed of availability of representation from the ND Protection and Advocacy Project (P & A). If requested, the SM assists the participants in accessing services with the P & A. P & A does not furnish other direct services or perform waiver functions.

**Appendix E: Participant Direction of Services****E-1: Overview (11 of 13)**

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The SM reviews with the participant's legal decision makers the ramifications of voluntary termination. Other support options including Medicaid State Plan services and other provider-directed waiver options are explored. The SM assists the family in transition activities to assure no breaks in service. Waiver services continue during the transition period.

**Appendix E: Participant Direction of Services****E-1: Overview (12 of 13)**

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the roles and responsibilities identified in the Participant Care Plan are not carried out and it is directly impacting the health and safety of the participant, the SM notifies the family/legal guardian that the participant-directing services are being terminated and review their right to appeal the termination of services offered through this waiver. Other support options including Medicaid State Plan services and other provider-directed waiver services are explored. The SM assists the participant in transition activities assuring that there is no gap in services.

The Participant Agreement and the Budget Authorization for self-directed services describes circumstances under which the service is terminated. Services will continue during the transition unless there are situations that immediately impact the health and safety of the individual.

Services may be involuntarily terminated if the parent or legal guardian were unable to self-direct services which resulted in a situation that jeopardized the child's health and welfare, medicaid fraud, the participant is no longer eligible for medicaid, or ineligible for ICF/IID level of care.

**Appendix E: Participant Direction of Services****E-1: Overview (13 of 13)**

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

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	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		25
Year 2		30
Year 3		35
Year 4		40
Year 5		47

**Appendix E: Participant Direction of Services**

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

a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

DRAFT

- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

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## Appendix E: Participant Direction of Services

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

b. **Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

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## Appendix E: Participant Direction of Services

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

b. **Participant - Budget Authority**

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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After the participant's team meets, the SM develops the individualized budget. The budget is based on the specific support needs of the participant, generic and informal resources available, and risk of unwanted out-of-home placement. Individualized budgets identify the funds that are available for each budget line item. The amount authorized for other self-directed supports are negotiated based on anticipated costs. The employer signs all individualized authorizations to indicate their approval and acknowledge their right to appeal. All individualized authorizations are also reviewed by the Autism Coordinator and must be approved through the Autism Services Unit before services can begin. All authorizations are reviewed after the quarter to audit the authorization back to the actual amount of funds utilized. This information is then considered as the next authorization is developed.

All Autism Unit Policy reflecting Budget Authority will be available via the Department's website and all Division Policies are distributed according to a mailing list of stakeholders and interested parties.

## **Appendix E: Participant Direction of Services**

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

#### **b. Participant - Budget Authority**

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The employer signs all individualized authorizations to indicate their approval of the projected budget and acknowledge their right to appeal.

The employer is informed of the opportunity to request a Fair Hearing when a request for a budget adjustment is denied or the amount of the budget is reduced through the Budget Authorization form. The employer signs this form before services can begin.

## **Appendix E: Participant Direction of Services**

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

#### **b. Participant - Budget Authority**

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## **Appendix E: Participant Direction of Services**

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

#### **b. Participant - Budget Authority**

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that

DRAFT

may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Fiscal Agent develops an on-line budget balance sheet that indicates total budget, percentage of expenditures and remaining funds. This information is available to the SMs. The employer receive the same information as payments are made or on a monthly basis if requested. Employers may also call the Fiscal Agent for updated information.

## **Appendix F: Participant Rights**

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### **Appendix F-1: Opportunity to Request a Fair Hearing**

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

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

The participant's family is given notice of their right to a Fair Hearing if they are not given the choice of Home and Community Based Services as an alternative to institutional care, are denied the service(s) of their choice, or the providers (s) of their choice; or whose services are denied, suspended, reduced or terminated. Each service authorization signed by family contains written notice of the grievance procedures and the right to request a fair hearing, to whom they must address the request, and that services may continue during the process if they request a hearing before the date of action. Notification of Rights at a minimum are provided to each waiver recipient by the SM at enrollment, prior to annual Participant Service Plan review, and whenever a recipient registers a concern regarding services.

The legal decision maker may contact the SM or State Autism Coordinator for instructions on how to request a fair hearing. The legal decision maker must request a hearing within 30 days of the date of the written notice. Hearing requests must be forwarded to Appeals Supervisor, ND Department of Human Services. The legal decision maker may represent the participant at the hearing or they may have an attorney, relative, friend or any other person to assist them. If the legal decision maker requests a hearing before the date of action, ND DHS will not terminate or reduce services until a decision is rendered after the hearing or the legal decision maker withdraws the request for a hearing, if the legal decision maker fails to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. The legal decision maker is advised, however, that if the hearing decision by DHS is not in their favor, the total additional amount paid with Medicaid funds on their behalf may be considered an overpayment subject to recovery.

The individual authorizations provide quarterly notice of rights to appeal adverse actions regarding reduction, denial, or termination of services. Families must sign and return the authorization on a quarterly basis prior to services being initiated for that quarter. The SMs mail the authorization to families and are available to assist the family with questions concerning exercising their rights.

The state autism coordinator keeps copies of correspondence regarding Notice of Adverse Actions, signed Participant Service Plans and Authorizations at the state Human Service Center.

Parents and legal decision makers are informed annually or whenever a service is changed of their right to appeal.

## **Appendix F: Participant-Rights**

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### **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**

**DRAFT**

**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.

The ND Department of Human Services assures that a family/legal guardian, who is dissatisfied with any decision or action, may request an informal conference in an attempt to resolve the issue. The request for formal conference must be submitted per Autism Services Unit policy. The use of informal conference will not preclude or delay the family/legal guardian's right to a fair hearing.

The request for an informal conference must be submitted to the State Autism Coordinator within 10 days after the written notice of the determination. The State Autism Coordinator shall, within 5 working days of an oral or written request, for an informal conference convene a conference with the aggrieved party. Within 5 additional working days after the informal conference, the State Autism Coordinator will issue a written decision. The SM will provide assistance to the grieved family/legal guardian with submitting an informal appeal and to describe the process of appeal.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)

**No. This Appendix does not apply** (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

DRAFT

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The definitions for abuse neglect and exploitation and the role of the P & A project are defined in NDCC 25-01.3. Definitions for child abuse and neglect for individuals under the age of 18 and the role of child protective services are contained in NDCC 50-25.1.

For provider managed services the provider will complete a State Form Number 960 to report the alleged abuse or neglect of a child to Children and Family Services. The reporter must notify the State Autism Coordinator.

#### Mandated Reporters

The Child Abuse & Neglect Law identifies people mandated to report suspicions of abuse and neglect. This list includes any physician, nurse, dentist, optometrist, dental hygienist, medical examiner or coroner, any other medical or mental health professional, religious practitioner of healing arts, school teacher or administrator, school counselor, addiction counselor, Social Worker, child care worker, foster parent, police or law enforcement officer, Juvenile Court personnel, Probation Officer, Division of Juvenile Services employee, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the Department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser. Any person having reasonable cause to suspect that a child is abused or neglected may report the circumstances to the department.

In order to fall under the mandate and intent of this law, it is not necessary that the child be physically (in the literal sense) before the reporter. Any mandated reporters named in NDCC Section 50-25.1-03, who would have knowledge of or reasonable cause to suspect child abuse or neglect as a result of information provided to them, would be required to report that belief, notwithstanding the fact that the child was not physically present before them. If the information provided to that individual in his or her professional capacity was sufficient to form the basis of a reasonable suspicion that child abuse or neglect had occurred, then that individual would be responsible for reporting that information as required by statute.

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

SMs provide families with written information regarding their rights (NDCC 25-01.2) and definitions of abuse and neglect. The information will be presented at a level consistent with the family's level of understanding and will include contact information to make a report. This information will be provided at the time of waiver enrollment and reviewed annually thereafter.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

For individuals, birth through seven, suspected abuse and neglect is reported to Child Protective Services (CPS) who is responsible for assessment/investigation and follow up relative to the report. Reports should be made to the county social service office where the child is currently physically present.

For individuals age birth through seven, for provider managed services, providers must report to CPS as well as P & A within eight hours of the serious event or ANE occurring or as soon as known.

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When a report involving an individual, ages birth through seven, is made to Child Protective Services the CPS worker must begin an assessment within 24 to 72 hours. The timeline will depend upon the nature and seriousness of the report as defined in protocol. The CPS worker is required to make a face-to-face contact with the child within 24 hours, 3 days or 14 days which is dependent upon the nature and seriousness of the report.

The written assessment/investigation with accompanying documentation must be completed and submitted to the regional child protection supervisor within 62 days unless an extension is requested and approved by the regional child protection supervisor.

The CPS worker must conduct a face-to-face meeting with the child (subject of the report) within the 62 days of the assessment period.

The Child Protection Social Worker completing the assessment of a report of suspected child abuse or neglect shall provide notification of the case decision to, the subject of the report. When the case decision is "Services Required", the notification to the subject shall be made face-to-face. If a face-to-face notification cannot be done, the reason needs to be documented. When the case decision is "No Services Required, the notification may be made either face-to-face or by telephone. Written notice of the case decision is also made to the subject of the report and to the parent(s) of the child(ren). Out of respect for the families involved in the assessments process, the report needs to be completed as soon as possible and notification be made to families of the decision. There is not a specific time frame established for this notification. For incidents that do not meet child protective services criteria, the report would be referred to P & A or Law enforcement may also be a referral depending upon the concerns reported.

The Child Protective Services within the Department of Human Services and its authorized agents (county social services offices) receive all reports of abuse, neglect or exploitation of a child. An assigned case worker will then review any and all material pertaining to the report along with personal interviews with identified individuals having any information regarding reported concerns. This information is given to an intra-disciplinary team of professionals who review and determine whether a child has been abused or neglects according to definition in state law and whether additional services are needed. The whole process is required to begin within 24 hours of receiving the initial report as per outlined in the established guidelines. The Central Office Administrator will follow-up with Child Protective Services concerning status of the child and resolution of investigation regarding all incidents reported under this section.

#### Reporters

The reporter brings the concerns of child abuse and neglect to the attention of the CPS agency. The primary responsibility of the reporter is to provide information regarding the alleged child victim(s), the person named as responsible for the child's health and welfare, and the incident(s), which caused a suspicion of child abuse and neglect. Reporters are required to provide written reports within forty-eight hours if so requested. A written report must contain information specifically sought by the department if the reporter possess or has reasonable access to that information. In addition, the reporter should be available to the CPS Social Worker for any further questions about the report.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

All reports and findings submitted to the Autism Services Unit for serious events and all other incidents reported as abuse, neglect and exploitation are entered into a data base maintained by the Autism Services Unit. Data will include information regarding children birth through seven years of age from Child Protective Services.

## 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

DRAFT

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 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).

Services within this waiver may not be used to implement discipline techniques or behavioral intervention strategies that are not age appropriate or that may place a participant at risk of abuse, neglect or harm such as corporal punishment, physical or prone restraint, etc. All training, tasks and programs that will be carried out by employees employed through self-directed supports must be identified in the Service Plan. This waiver will not authorize funds to implement inappropriate methods.

When challenging behaviors are identified, the SM notifies the Program Design and Monitoring professional for review and recommendations. In the event restraints or seclusion would be appropriate, the plan must be reviewed and approved by Program Design and Monitoring professionals.

Families and employees will receive information defining restraints and seclusion and their responsibility to report all known incidents of unauthorized restraint and seclusion to Child Protective Services. For provider managed services the employee will report within twenty-four hours, or as soon as becoming aware of the situation, to CPS and the State Autism Coordinator.

Restraints or seclusion will be an exception and must be reviewed and designed by a Program Design and Monitoring professional to assure all other less restrictive approaches have been implemented and the risk analysis supports the intervention recommended. Data collection and on-going monitoring is also required.

- 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:

The Autism Services Unit maintains a data base regarding use of restraints and restrictive interventions. The data is reviewed at least quarterly by the State Autism Services Unit.

## **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 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

**DRAFT**

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.

Services within this waiver may not be used to implement discipline techniques or behavioral intervention strategies that are not age appropriate or that may place a participant at risk of abuse, neglect or harm such as corporal punishment, physical or prone restraint, etc. All training, tasks and programs that will be carried out by employees employed through self-directed supports must be identified in the Service Plan. This waiver will not authorize funds to implement inappropriate methods.

When challenging behaviors are identified, the SM notifies the Program Design and Monitoring professional for review and recommendations. In the event restrictive interventions would be appropriate, the plan must be reviewed and approved by Program Design and Monitoring professionals.

Families and employees will receive information defining restrictive interventions and their responsibility to report all known incidents of unauthorized restrictive intervention(s) to Child Protective Services. For provider managed services the employee will report within twenty-four hours, or as soon as becoming aware of the situation, to CPS and the State Autism Coordinator.

Restrictive interventions will be used as an exception and must be reviewed and designed by a Program Design and Monitoring professional to assure all other less restrictive approaches have been implemented and the risk analysis supports the intervention recommended. Data collection and on-going monitoring is also required.

- 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:

The Autism Services Unit maintains a data base regarding use of restraints and restrictive interventions. The data is reviewed at least quarterly by the State Autism Services Unit.

## **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.

- 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.

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## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

##### 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).

##### 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:

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(b) Specify the types of medication errors that providers are required to *record*:

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(c) Specify the types of medication errors that providers must *report* to the State:

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- 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:

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- 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.

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**Appendix G: Participant Safeguards**

**Quality Improvement: Health and Welfare**

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

**a. Methods for Discovery: Health and Welfare**

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

**i. Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

(G-1) The number and percent of participants who have a signed Individual Rights and Service Plan (IRSP), stating they have been informed of their rights including Abuse & Neglect and reporting procedures. N: The number and percent of participant's who have a signed IRSP, stating they have been informed of their rights, including A & N and reporting procedures. D: All IRSPs reviewed from sample.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Secure Electronic database

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

DRAFT

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

(G-2) Number and percent of reports where Abuse and Neglect are substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number and percent of reports where Abuse and Neglect are substantiated, where follow-up is completed on recommendations for waiver service providers. D: All substantiated assessments.

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

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<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**(G-3) Number and percent of unauthorized restrictive interventions that were substantiated through investigation, where follow-up is completed as required. N: Number and percent of unauthorized restrictive interventions that were substantiated through investigation, where follow-up is completed as required. D: Total number of unauthorized restraints reported.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

(G-4) Number and percent of reported elopment attempts of waiver participants.  
 N: Number and percent of reported elopment attempts of waiver participants. D: Total number of waiver participants.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

Report submitted to the state autism coordinator

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
SMs review incident investigations and implementation of recommendations to prevent reoccurrence. If the issue cannot be resolved, the SM informs the Autism Services Unit. Quarterly meetings with the Protection and Advocacy Project to address review of incident report trends, and training activities, incident report system policies and procedures.

**ii. Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

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

**Appendix H: Quality Improvement Strategy (1 of 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.

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- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement 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 Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement 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/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Autism Services Unit is responsible for evaluating the effectiveness and outcomes of the discovery, remediation, and quality improvement plans. The Unit prioritizes its remediation efforts to address any problems that involve client care or health and welfare issues first. The Unit keeps track of its quality improvement efforts by maintaining databases and statistics that include applicable timeframes for completion. The Unit uses this information to make necessary changes to improve quality.

When predetermined performance measures are not met or problems (that are not directly related to participant care or health, welfare, and safety issues) are identified, the Unit develops a plan of action. The

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action plan is documented and may include providing information to service managers and updating policy/protocol as needed. If the problem involves client care, health, welfare, and safety issues the problem is addressed immediately. Policy is updated as appropriate.

**ii. System Improvement Activities**

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Other Specify: _____

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

The effectiveness of system design changes is evident through ongoing monitoring activities using the established performance measures.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Based on the review of the Quality Management System, the Autism Services Unit reviews the following on an annual basis:

- (1) Information Technology needs
- (2) Verify quality of data
- (3) Verify quality of data analysis
- (4) Identify strategy gaps
- (5) Review Workflow Process
- (6) Review the Sampling Methodology for appropriateness

Following review of the above items, necessary adjustments are made to the Quality Improvement Strategy.

**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).

All self-directed service payments are made through a contracted Fiscal Agent. The Fiscal Agent disburses payments for services authorized by the individual’s Service Plan. The Fiscal Agent maintains records of all payments and account credits which are available on-line to individuals receiving services, the SM, and to the Medicaid agency. If families request, a copy of the balance sheet report is mailed to them monthly or as requested. Families are made

DRAFT

aware of how they can access information through the initial sign up packet which the SM reviews with the family. The SM reviews actual usage of supports quarterly and updates the individual authorization to reflect actual amount of contract used. The Fiscal Agent bills through the ND MMIS payment system, by participant, monthly for the expenses paid on behalf of each participant. The authorization process prevents over billing by the fiscal agent as the MMIS payment system has edits that prohibit payments in excess of authorized budget limits. The Fiscal Agent codes each payment according to the type of benefit paid and annually produces a report with total payments for each code. The contract with the Fiscal Agent requires an annual independent audit. The MMIS payment system, authorizations and Fiscal Agents fees will be compared every six months by the Autism Services Unit to identify and address any discrepancies. The autism services unit staff monitors monthly budget program spend down reports generated through MMIS payment system and monthly contract billings for fiscal agent services.

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. EDTs determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). The state autism coordinator then authorizes services on the Participant Service Plan in web based data system.

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

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

#### **a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

##### **i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

##### **Performance Measure:**

**(I-1) Number and percent of the ASD Waiver claims paid out at the authorized amount.**

**N: Number and percent of the ASD Waiver claims paid out at the authorized amount.**

**D: Total number of claims.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Medicaid payment system**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

DRAFT

(I-2) Number and percent of fiscal agent payment rates that are consistent with the rate methodology in the approved waiver or subsequent amendment. N: Number consistent fiscal agent payment rates. D: Total number of payment rates.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Fiscal agent report/MMIS report**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

DRAFT

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<input type="checkbox"/> Other Specify:

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

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The claims processing unit reviews all suspended claims and advises the provider if the claim is not properly coded. The provider will receive a remittance advice with a code indicating the cause of the suspension. The provider and the autism coordinator work together to correct the billing error.

Errors in payments for participants’ claims are directed to designated contacts of the Fiscal Agent or to the SM. Issues are logged by the SM and discussed as needed with the Autism Services Unit staff. If there are unresolved issues, Autism Services Unit staff meet with Fiscal Agent management to resolve the specific issues and devise procedures to avoid further errors. Those meetings occur as needed.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

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

DRAFT

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Program Design and Monitoring, Skills Training, Service Management, and Respite Care are provider managed services in the Autism Waiver. The service delivery is based on a fee for service model, which reimburses for the delivery of the services and related administrative costs.

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

The waiver services is delivered, then the provider bills ND MMIS electronically, the claims are reviewed and analyzed, claims are then paid if accurate or suspended until corrections are submitted.

## Appendix I: Financial Accountability

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

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

- No. State or local government agencies do not certify expenditures for waiver services.
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

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

- Certified Public Expenditures (CPE) of Local Government Agencies.**

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

DRAFT

## 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 EDT (re)assesses the Level of Care (LOC) as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). After the determination of the LOC the Autism Services Unit staff authorizes services on the Individual Rights and Service Plan in the web based data system.

The ICF/ID Level of Care determinations are entered into an MMIS payment system file. Only one code can be entered per individual assuring that services cannot be duplicated. The Individual Rights and Service Plan information authorizing a waiver service is entered into the MMIS system which includes the service authorized, dates for which authorized, provider number and Medicaid number and rate and frequency. Numerous edits assure that claims are paid properly. In order for a claim to be paid for waiver services, the system 1) determines the individual is currently eligible for MA, 2) the person has a current level of care screening and code for autism waiver services, 3) the service is currently authorized by Autism Services Unit staff, 4) the billed rate is correct for that individual, provider, or program, 5) units billed are within authorized amounts, 6) units billed are within maximum allowable, 7) there are no competing claims for the same service and time period. If any of the above are absent from the system or conflict, the claim will suspend or be denied. The claims reviewer receives a report of suspended claims and the reason for suspension.

For Self Directed Supports, Service Managers complete an individualized authorization document. Through an automated work flow process, this is forwarded to the state autism coordinator for review and approval. With final state office approval the authorized amount and dates of service, the rate, and authorized provider are entered into that data system.

Additional checks are in place to assure services are received as billed. At least every 90 days the SM meets with the participant to complete a Quality Enhancement Review. Included in that review is whether or not the service has been provided and the individual's satisfaction with it.

In the budget determination process, an authorization document is developed listing the amount and type of service and the overall budget. When that document is approved by the regional state autism coordinator, the information listed above is entered into the eligibility file which authorizes and limits billing by the Fiscal Agent. The authorization document is also then forwarded to the Fiscal Agent where payment limits are established in their payment systems. Requests for payment to the Fiscal Agent are checked against those records to determine if payment should be made. Payments by the Fiscal Agent are made at the direction of the family according to invoices for approved goods and services and timesheets for direct service providers.

In the event that changes are needed to the budget or adjustments are needed within service categories in the approved budget, the Autism Services Unit staff updates the authorization. At the end of each quarter, unused funds are recouped and a new service authorization developed.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

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- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

A Fiscal Agent is used for self-directed service payments. In self-directed services, participants direct bills or invoices to the Fiscal Agent. The Fiscal Agent pays the vendor, codes the claims as to specific type, and bills through the state claims payment system. On-line accounts are available for participants, the SM monitors individual budgets, and account balances. Quarterly reports of the Fiscal Agent are available to the Autism Services Unit and the Fiscal Agent annually provides detail for the 372 reports.

The same Fiscal Agent assures that payments do not exceed the budget within the individualized authorization, develop and maintain employee files, pay the employees the families have hired, pay the vendors selected by the families, and withhold and report all required state and federal taxes and benefits.

Quarterly, the SM reviews with the family the amount of services utilized and adjust the budget within the individualized authorization back to actual.

Monthly contract billings for Fiscal Agent services are reviewed to assure they are only billing for individuals approved to receive waiver services. MMIS data, authorizations and Fiscal Agents fees will be compared every 6 months.

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

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

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

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

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

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

- d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

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

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

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

- e. **Amount of Payment to State or Local Government Providers.**

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

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

DRAFT

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

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## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

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## 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.

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ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCD) arrangements under the provisions of 42 CFR §447.10.

DRAFT

- 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) (MCO) 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 State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

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

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an

**DRAFT**

Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

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

**DRAFT**

**Appendix I: Financial Accountability****I-5: Exclusion of Medicaid Payment for Room and Board****a. Services Furnished in Residential Settings.***Select one:*

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

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.**The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:  
**Do not complete this item.****Appendix I: Financial Accountability****I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver****Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.***Select one:*

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

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

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)****a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

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

**i. Co-Pay Arrangement.**

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

**DRAFT**

*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.

**DRAFT**

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:

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## **Appendix J: Cost Neutrality Demonstration**

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### **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.

Further information concerning a composite overview of the waiver cost neutrality (Appendix J) can be obtained by contacting (this would be your information) Trisha Page, Program Administrator at [tpage@nd.gov](mailto:tpage@nd.gov), or writing a request for information to 1237 West Divide Avenue Suite 1A, Bismarck, ND 58501 or by calling 701-328-8949.

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