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:
Traditional IID/DD Home and Community Based Services Waiver

C. Waiver Number:ND.0037
Original Base Waiver Number: ND.0037.

D. Amendment Number:

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

01/01/15

Approved Effective Date of Waiver being Amended: 04/01/14

2. Purpose(s) of Amendment

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

- Revised the maximum number of unduplicated waiver recipients who will be served during the waiver period for year one and two
- Submit a transition plan to accommodate HCB setting characteristics rule
- Clarified person centered planning process

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☑ **Appendix B Participant Access and Eligibility**	B-3 (1of 4)a
☑ **Appendix C Participant Services**	C-5
☑ **Appendix D Participant Centered Service Planning and Delivery**	D-1 (1of 8) (4 of 8), (5 of 8), D-2a
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
Appendix H	

DRAFT

☐	
☐ **Appendix I ◆ Financial Accountability**	
☑ **Appendix J ◆ Cost-Neutrality Demonstration**	J-1, J-2 (1 of 9) (5 of 9)

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

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

Specify:

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

1. Request Information (1 of 3)

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

Traditional IID/DD Home and Community Based Services Waiver

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**

Original Base Waiver Number: ND.0037
Draft ID: ND.007.07.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/14
Approved Effective Date of Waiver being Amended: 04/01/14

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 in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

DRAFT

○ **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 with intellectual disabilities with related conditions and cognitive impairment.

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)**

☐ **§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 Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

North Dakota's Home and Community Based Waiver for Individuals with Intellectual Disabilities (IID) and related conditions provides an array of provider managed and participant directed services in order for individuals of all ages to have the opportunity to receive community alternatives to institutional placement. The waiver is an integral part of the North Dakota's Money Follows the Person Grant and the State's goal to reduce the number of individuals residing in the State operated ICF/IID. The State Medicaid agency, which is under the umbrella of the North Dakota Department of Human Services, is responsible to administer the waiver.

Applicants may access waiver services at the eight regional human service centers located throughout the State. The DD Program unit at each human service center is responsible for the determination of eligibility, to assist participants in accessing waiver services and monitoring of services selected by the participant. Services and supports are provided by private non and for-profit providers licensed by the Developmental Disabilities (DD) Division; and qualified service providers who are independent contractors enrolled with Medical Services within the Department of Human Services (Department). A fiscal agent assists participants and their families who wish to self-direct their

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

DRAFT

5. Assurances

In accordance with 42 CFR ⁄441.302, the State provides the following assurances to CMS:

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

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

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

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

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

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

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

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

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

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

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

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence

DRAFT

of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR ◆440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR ◆ 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR ◆431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of ◆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, 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 Department sent a notice to all Tribal Chairman, Tribal Health Directors and Indian Health Service Representatives in North Dakota notifying them of the Departments intent to submit an amendment to increase capacity. The letter included a description of the amendment and explained the process to provide input.

The Department also provided opportunities for public comment on the amendment of the Traditional IID/DD waiver to increase waiver capacity in the following manner: 1) a public notice and a press release are issued to seek public comment on the waiver amendment 2) the amended waiver and public notice were posted on the Department's website.

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

DRAFT

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

7. Contact Person(s)

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

Last Name:

Krein

First Name:

Marella

Title:

DD HCBS Waiver Administrator

Agency:

Developmental Disabilities Division

Address:

1237 West Divide Avenue, Suite 1A

Address 2:

City:

Bismarck

State:

North Dakota

Zip:

58501-1208

Phone:

(701) 328-8977 **Ext:** ☐ **TTY**

Fax:

(701) 328-8969

E-mail:

mkrein@nd.gov

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

Last Name:

Bay

First Name:

DRAFT

Tina

Title:

DD Director

Agency:

Developmental Disabilities Division

Address:

1237 West Divide Avenue, Suite 1A

Address 2:

City:

Bismarck

State:

North Dakota

Zip:

58501-1208

Phone:

(701) 328-8966 **Ext:** ☐ **TTY**

Fax:

(701) 328-8969

E-mail:

tbay@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:

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:

DRAFT

Julie

Title:

State Medicaid Director

Agency:

Medical Services Division, Department of Human Services

Address:

600 East Boulevard Avenue #325

Address 2:

City:

Bismarck

State:

North Dakota

Zip:

58505

Phone:

(701) 328-1603 **Ext:** ☐ **TTY**

Fax:

(701) 328-1544

E-mail:

jfschwab@nd.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

DRAFT

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

North Dakota Preliminary Transition Plan – Assessment of Settings Process

North Dakota offers fifteen services through its Home and Community Based Services (Traditional IID/DD) 1915(c) waiver. Approximately 37 DD providers are enrolled to provide DD HCBS services. There are 29 providers enrolled to provide Residential Habilitation, 22 providers enrolled to provide Extended Services, 28 providers enrolled to provide Day Support services, and 38 providers enrolled to provide Adult Day Health services.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

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

Appendix A: Waiver Administration and Operation

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

   ⦿ **The waiver is operated by the State Medicaid agency.**

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   Developmental Disabilities Division

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

DRAFT

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 DD Division and Medical Services. The DD Division, 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.

Appendix A: Waiver Administration and Operation

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

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

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

  Contract for Fiscal Agent services for waiver supports that are participant directed.

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

Appendix A: Waiver Administration and Operation

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

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

  Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or

DRAFT

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), Developmental Disabilities Division (DD Division), will monitor the Fiscal Agent contract per Department contract oversight protocol.

Appendix A: Waiver Administration and Operation

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

Fiscal Agent activities will be continually monitored by families and DD Program Managers (DDPMs) through on-line individual balance sheet reports. Feedback will be solicited from staff working with the Fiscal Agent to measure satisfaction with current contractor.

The fiscal agent contract is monitored by monthly calls with DD Division Staff, monthly reports to the regional administrators and ongoing telephone contact with families and DDPMs.

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

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR ◆431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
(A-1) Number and percent of self-directed services correctly paid by the Fiscal Agent that are authorized on the participant's authorization. N: Number of authorized services, correctly paid for by the Fiscal Agent that is on the Traditional waiver authorization self-directed supports. 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

Performance Measure:
(A-2) The number and percent of transportation vendors providing self-directed services, whose qualifications are verified by the Fiscal Agent prior to delivering services. N: Number of transportation vendors providing self-directed services, whose qualifications are verified by the Fiscal Agent prior to delivering services. D: All transportation vendors providing self-directed services.

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

DRAFT

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The DD Division staff is responsible for addressing individual problems. Problems may be corrected by providing one on one or group training /education, clarifying/rewriting policy, recouping funds that were paid in error, or termination of provider status if necessary. The state maintains documentation that tracks training, policy changes, recouped funds and terminations.

(A-1) Upon discovery, Fiscal Agent contacts DDPM for any services not on the authorization. DDPM works with family to resolve the issue. Issue and solution are documented in web based data system by DDPM. DDPM communicates resolution to Fiscal Agent.

ii. Remediation Data Aggregation

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

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

DRAFT

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☑	**Developmental Disability**	0		☑
	☑	**Intellectual Disability**	0		☑
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

The state additionally limits the waiver to individuals with intellectual disabilities or individuals with related conditions and cognitive impairment.

DRAFT

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:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage:

- ( ) **Other**

  Specify:

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

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

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

- ( ) **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

DRAFT

○ **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)**

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:

DRAFT

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5260
Year 2	5365
Year 3	4870
Year 4	4975
Year 5	5080

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)

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).**

Purpose(s) the State reserves capacity for:

Purposes	
Emergency	
Transition from Supported Employment to Extended Services	
Early Intervention	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

DRAFT

Emergency

Purpose *(describe):*

The State reserves slots for emergency situations in which potentially eligible participants are in need of supports to ensure health and welfare.

A person is considered to have emergency needs when: The individual is at significant, imminent risk of serious harm because the primary caregiver(s)/support system is/are not able to provide the level of support necessary to meet the person's basic needs; and/or the individual requires protection from confirmed abuse, neglect, or exploitation; and whose needs can be addressed through licensed DD waiver services.

Describe how the amount of reserved capacity was determined:

Based on current enrollment, trend data from the State Review Team, ND Life Skills and Transition Center, ND State Hospital, and Regional DD Program Administrators.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4 (renewal only)	50
Year 5 (renewal only)	50

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Transition from Supported Employment to Extended Services

Purpose *(describe):*

In order to assure individuals have access to the placement, training, stabilization phase of supported employment, slots are reserved. Vocational Rehabilitation will not provide supportive employment without prior assurance that funding is available for long term supported employment supports once placement, training and stabilization are complete. Some individuals may not be receiving a waiver service at the time of entrance to Supported Employment Program (SEP) and it can last up to 18 months before transition to Extended Services. The reserve capacity assures continuity of SEP services long term for individuals who are not enrolled in the waiver at initiation of SEP.

Describe how the amount of reserved capacity was determined:

The case management information system was queried to determine how many participants are currently receiving SEP through Vocational Rehabilitation and would likely transition to Extended Services during Year 1 of the waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4 (renewal only)	5
Year 5 (renewal only)	5

DRAFT

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Early Intervention

Purpose *(describe):*

The State will reserve slots for children birth to three years of age to provide intervention in a timely manner for young children who will benefit from early intervention services. The primary caregiver chooses which option best meets their family's needs. If they choose waiver funded services, reserved slots will be assigned based on eligibility date once general waiver slots have been reached.

Describe how the amount of reserved capacity was determined:

Based on current waiver enrollment and trend data.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	135
Year 2	135
Year 3	135
Year 4 (renewal only)	135
Year 5 (renewal only)	135

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, minus the reserved slots, the eligible participants will be enrolled on a first-come, first-serve basis. When the cap is reached, a waiting list based on time of application will be used. If the reserved capacity for 'Emergency' has been exhausted, applicants whose situation meets the definition for 'Emergency' will be given priority on the waiting list.

DRAFT

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**

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

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

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☑ **Medically needy 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:

Individuals eligible under sections 1902(a)(10)(A)(i)(I),(IV),(VI),and (VII); section 1902(a)(10)(C)(ii)(I); section 1902 (a)(52)of the SSA; 42 CFR 435.308 and .310; and all other optional eligibility groups covered under the ND State Plan.

Special home and community-based waiver group under 42 CFR ⊘435.217) *Note: When the special home and community-based waiver*

DRAFT

group under 42 CFR ◆435.217 is included, Appendix B-5 must be completed

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **A special income level equal to:**

  Select one:

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

    Specify percentage: [ ]
  - ( ) **A dollar amount which is lower than 300%.**

    Specify dollar amount: [ ]
- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

  Select one:

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

    Specify percentage amount: [ ]
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  [ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR ◆441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR ◆435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR ◆435.217 group. A State that uses spousal impoverishment rules under ◆1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under ◆1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

DRAFT

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance 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:

Minimum frequency: Quarterly

Individuals are screened to the ICF/IID level of care when it is expected that the person will need and receive a waiver service within 30 days and that waiver services will be furnished at least quarterly. It is expected that non• intermittent services will be delivered monthly.

when a participant is only receiving an intermittent service, such as Environmental Modification or Transportation, the service may not be delivered during a particular month. The DDPM will monitor the use of services as part of the quarterly enhancement review (QER). If, based on the QER, the

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

⊙ **Directly by the Medicaid agency**

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

Specify the entity:

- ○ **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:

DDPMs at the Regional Human Service Centers will perform the initial evaluation of level of care for waiver applicants. The minimum qualifications for DDPMs require that they meet the criteria for Qualified Developmental Disabilities Professional (QDDP). This criteria is as follows:
Definition: Individual who:
483.430(a)(1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and
(a)(2) Is one of the following:
(a)(2)(i) A doctor of medicine osteopathy

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.

Individuals that may be eligible for ICF/IID level of care include individuals with a diagnosis of intellectual developmental disabilities as defined in ND Administrative Code 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009 with accompanying cognitive limitations, and who are eligible for Medicaid. An evaluation instrument is used in North Dakota to determine whether an individual meets the minimum criteria for ICF/IID level of care. The evaluation instrument is a component of an automated system and is used to assess individual strengths and needs and to assist in the determination of eligibility as well as evaluation of level of care. The individual assessment describes the most current DSM diagnoses and the level of supports needed by an individual in the following areas: residential, day services, motor skills, independent living, social, cognitive, communication, adaptive skills, behavior, medical and legal. Once the evaluation is completed, an indicator is electronically derived from the scores that determine whether an individual meets the basic criteria for the ICF/IID level of care, if all other criteria are met. The HCBS indicator, in conjunction with the professional judgment of the DDPM, will serve as the basis as to whether the individual will be screened for waiver services.

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 DDPM will obtain psychological, medical, educational and other relevant assessments and information as part of the application and intake process to the Regional Human Service Center. The DDPM will schedule an interview/visit with the individual and/or legal decision maker, to assess the individual's needs and desired outcomes. During the initial visit(s), the DDPM will complete the evaluation instrument. The evaluation results are entered into the web based data system to determine if the minimum criteria are met for level of care. If the finding is affirmative, the DDPM will complete the Case Action Form to document the level of care for the MMIS payment system. If it is determined the individual does not meet the level of care, the individual and/or legal decision maker will be notified of their right to appeal the adverse decision. The level of care criteria used for the re-evaluation is the same criteria applied for the initial level of care. The DDPM will complete the Progress Assessment Review (PAR) 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 will be beneficial or is needed. The results are entered into the web based data system to determine if the minimum criteria are met for level of care and continued enrollment in waiver services. If the finding is affirmative and all other criteria are met, the DDPM will complete the Case Action Form to document the level of care for

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):*

When the evaluation results are completed and activated, a system generated alert due date is calculated to plus one year minus one day to ensure that the re-evaluation of level of care is performed on a timely basis. In addition, when the Case Action Form is completed and activated, a system generated alert is created with an alert due date equal to the active case action termination date or end date, minus two months to ensure that the re-evaluation of level of care is performed on a timely basis and entered into MMIS. The DDPM and their supervisors have the ability to review all alerts by manager assigned caseload, due date, type of alert, individual case.

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 for each individual for a minimum of 3 years+ in the web based data system application which can be accessed at the Regional Human Service Center or DD Division. 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**

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
(B-1) Number and percent of new waiver enrollees who had an initial LOC indicating need for ICF/IID LOC prior to receipt of services. N: Number of new waiver enrollees who had a LOC prior to receiving services. D: All new waiver enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Query from web based 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess

DRAFT

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

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

Performance Measures

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

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

Performance Measure:
(B-2) Number and percent of waiver participants who have an accurately completed initial level of care determination. N: Waiver participants who have an accurately completed initial level of care determination. D: Sample of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Queries from web based data system - Manual Level of Care Integrity Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

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

The DD Division reviews patterns and trends of inaccurate PARs/LOC determinations that result in a licensing deficiency and require a corrective action plan. The DD Division follows up, to ensure the corrective action plan is completed (addressed in B-2 below).

Patterns of errors will be analyzed to determine if they are the result of individual, region, or systemic issues. The Regional DD Program Administrators (DDPAs) will address individual issues and Regional training needs. The DD Division is available to assist Regional DD Program Administrators, as well as addressing systemic issues.

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.

It is the responsibility of the DDPM to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance.

(B-1) When the DD Division is notified that a LOC is not completed either through quarterly case reviews or through denied or suspended claims, the DD Division will contact the DDPA for information or correction. The DDPA contacts the DDPM for information and to complete the LOC. The DD Division is then notified upon completion of the corrective action plan.

ii. Remediation Data Aggregation

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

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

DRAFT

	Specify:

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals eligible for the waiver will be provided with a choice of institutional or HCBS services, feasible alternatives under available waivers will be explained by the DDPM and a description of services and list of all available DD Licensed Providers will be provided to the individual and/or legal representative. The individual choice will be documented on the Individual Service Plan (ISP). This information will be 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 ISP is maintained in the participant's file at the Regional Human Service Center for more than three years.

Appendix B: Participant Access and Eligibility

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

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

The services of an interpreter will be arranged when a participant and/or their legally responsible caregiver is unable to independently communicate with the DD Division staff, DDPM/DDPA, or the fiscal agent. 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		

DRAFT

Statutory Service	**Adult Day Health**		
Statutory Service	**Day Supports**		
Statutory Service	**Extended Services**		
Statutory Service	**Homemaker**		
Statutory Service	**Residential Habilitation**		
Extended State Plan Service	**Extended Home Health Care**		
Other Service	**Adult Family Foster Care**		
Other Service	**Behavioral Consultation**		
Other Service	**Environmental Modifications**		
Other Service	**Equipment and Supplies**		
Other Service	**Family Care Option**		
Other Service	**In-Home Supports**		
Other Service	**Infant Development**		
Other Service	**Parenting Support**		
Other Service	**Transportation Costs for Financially Responsible Caregiver**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

DRAFT

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope):*

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

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

Adult Day Health\Adult Day Care service requires that a minimum of three hours per day through a maximum of 10 hours per day, on a regularly scheduled basis, for one or more days per week.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Adult Day Care provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Care provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DRAFT

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

DRAFT

Service Definition *(Scope):*

Day Supports provide assistance to the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Day Supports are generally furnished in a non-residential setting, separate from the home or facility where the participant resides, but may be furnished in the individual's home during traditional Day Supports schedules if the individual(s)' needs preclude traveling from the home on a regular basis. Day Supports focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech therapies listed in the participant's plan. Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the participant's plan and the service originates from the licensed day program.

Rates for Day Supports may include transportation costs to access program related activities in the community. Transportation does not include travel between the individual's home and the Day Supports program site. Any transportation provided to an individual as a part of the rate is not billable as a discrete service.

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

An individual may be enrolled concurrently in Day Supports, Extended Services and Adult Day Health, per DD Division policy. However, Adult Day Health, Day Supports, and hours of employment in Extended Services combined cannot exceed 40 hours per week. Billing for services may not be duplicated for a time period (i.e. billed for both 1 to 5 p.m. on April 1.)

Provider managed Day Support may not be billed at the same time as Extended Services, State Plan Personal Care Services, In-Home Supports, Family Care Option, Family Care Option III, Residential Habilitation, Adult Day Health, or Homemaker services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Licensed DD Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Licensed DD Provider

Provider Qualifications

License *(specify):*

Licensed to provide Day Habilitation according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

Frequency of Verification:

Annually

DRAFT

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Extended Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Extended Services is ongoing support for an individual in supported employment upon completion of training and stabilization in employment; providing on or off the job employment-related support for individuals needing intervention to assist them in maintaining employment. This may include job development, replacement in the event of job loss, and, for provider managed services, must include a minimum of two onsite job skills training contacts per month and other support services as needed to maintain employment. It may also include providing other support services at or away from the worksite. If offsite monitoring is appropriate, it must, at a minimum, consist of two meetings with the individual and one contact with the employer each month.

Transportation costs for individuals from their residence to their workplace may be included in the service rate when an individual needs it as a support intervention necessary for the individual to maintain employment. It is not allowed as a substitute for personal, public or generic transportation, is not billable as a

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

An individual may be enrolled concurrently in Day Supports, Extended Services and Adult Day Health, per Division policy. However, Adult Day Health, Day Supports, and hours of employment in Extended Services combined cannot exceed 40 hours per week. Billing for services may not be duplicated for a time period (i.e. billed for both 1 to 5 p.m. on April 1.)

Provider managed Extended Services may not be billed at the same time as Day Supports, State Plan Personal Care Services, In-Home Supports, Family Care Option, Family Care Option III, Residential Habilitation, Adult Day Health, or Homemaker services.

DRAFT

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	Licensed Extended Services Provider
Individual	Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Extended Services

Provider Category:

Agency

Provider Type:

Licensed Extended Services Provider

Provider Qualifications

License *(specify)*:

Developmental Disabilities service provider licensed to provide Extended Services per ND Administrative Code 75-04-01.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

Frequency of Verification:

Annual license renewal

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Extended Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

For self-directed service delivery the individual provider must be 18 years or older.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent

Frequency of Verification:

Prior to hiring

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

The purpose of homemaker services is to complete environmental tasks that an individual with a disability is not able to complete in order to maintain that individual's home such as housework, meal preparation, laundry, shopping, communication, and managing money. Homemaker service is offered to participants living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks. If the participant lives with a capable person or provider, prior approval from the State office is required.

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

If shopping is the only identified task for homemaker services, homemaker services should not be authorized. Transportation or escorting the client is not an allowable task under Homemaker services.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. This amount allows for approximately 12 hours of service per month at the highest provider rate allowed. This cap may be increased as determined by legislative action. The DDPM informs a participant of the service cap.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Service Provider
Individual	Qualified Service Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Qualified Service Provider

DRAFT

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Qualified Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a QSP according to NDAC 75-03-23-07 and demonstrates competencies in homemaker standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

DRAFT

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Residential Habilitation consists of an integrated array of individually designed training activities, assistance and supervision. Residential Habilitation is provided in licensed/unlicensed community residential settings that include group homes and homes leased, owned or controlled by individuals.

Residential Habilitation includes:

(i) Habilitation Services aimed at assisting the participant to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the participant to improve his/her ability to

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

Participants who receive Residential Habilitation may not receive In-Home Supports, Family Care Option, Parenting Support, State Plan Personal Care Services, Adult Family Foster Care, Behavior Consultation, or Homemaker Services.

Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.

This service is not available at the same time of day as Day Supports, Extended Services or one of the State Plan Medicaid services that works directly with the person.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Provider Qualifications

License *(specify):*

Licensed according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

Frequency of Verification:

Annual license renewals

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended Home Health Care

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Extended Home Health Care is an Extended State Plan Service which is available when an eligible participant has maximized the amount of service available under the Medicaid State Plan. The participant's plan must address health and safety issues and support Home Health Care as a service necessary in order for the eligible participant to remain in a family (natural or adoptive) setting in their community.

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

This service is not available to participants receiving Residential Habilitation.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

DRAFT

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Extended Home Health Care

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certified as a Home Health Care provider under Medicare or a DD Licensed Provider of In-Home Supports, Family Care Option, Family Care Option III Services

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency and DD Division

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:

Adult Family Foster Care

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope):*

Assistance is provided to a participant for ADL's, IADL's and supportive services provided in a licensed private home by an Adult Family Foster Care provider that lives in the home. Adult Family Foster Care (AFFC) is provided to adults who receive these services while residing in a licensed AFFC home.

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

Service must be provided in a licensed AFFC home. Services are provided to the extent permitted under state law.

AFFC may not be provided in conjunction with Residential Habilitation, In-Home Supports, Family Care Option, Homemaker Services, Parenting Support, Transportation costs the Financially Responsible Caregiver, Equipment and Supplies, Environmental Modifications or with Medicaid State Plan Personal Care services. Non-medical transportation is a component of AFFC and is included in the rate. Room and board costs are not included in the AFFC payment.

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	Licensed AFFC provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adult Family Foster Care

Provider Category:

Individual

Provider Type:

Licensed AFFC provider

Provider Qualifications

License *(specify):*

Licensed according to NDCC 50-11, NDAC 75-03-21

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a Qualified Service Provider according to NDAC 75-03-23-07.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, Aging Services and Medical Services Divisions.

Frequency of Verification:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Consultation

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Funds for this service may be accessed to meet the excess disability related expenses associated with maintaining a participant in their primary caregiver's home and not covered through the Medicaid State Plan. Behavioral Consultation Services provide expertise, training and technical assistance to assist primary caregivers, and other natural supports, to develop an intervention plan designed to address target behaviors. Allowable activities covered are:
(1) Observing the participant to determine needs;
(2) Assessing any current interventions for effectiveness;
(3) Developing a written intervention plan;

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

Limitations are for the development and the evaluation of the plan and training of the primary caregiver. Behavioral Consultation does not include implementation of the plan by the behavior consultants and training of staff.

Behavioral Consultation excludes services provided through the IEP.

Behavioral Consultation is limited to $5200 per participant per State Fiscal Year per participant unless an exception is approved by the DHS/DDD to prevent imminent institutionalization.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Consultation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

A currently licensed ND Behavior Analyst, ND Registered Behavioral Analyst, ND Psychiatrist or Psychologist

Certificate *(specify):*

A currently certified ND Behavior Modifications Specialists or QDDP through a licensed DD Provider within the participant's plan of care

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division, DDPM

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

DRAFT

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Funds for this service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a participant living in their own home or in the home of their primary caregiver. This home must be owned by the participant or the participant's primary caregiver.

Environmental Modifications consists of modifications made to a participant's home or vehicle. Home Modifications are age appropriate physical modifications required by the individual's plan of care developed by the participant's team, which are necessary to ensure the health, welfare, and safety of the participant or/and enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the participant.

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

The amount of service for environmental and vehicle modifications will not exceed $20,000 per participant for the duration of the waiver. The authorization database will track the amount authorized and utilized to prevent over-expenditure.

Items that are not of direct or remedial benefit to the participant are excluded from this service.

Repair of items purchased through the waiver or purchased prior to waiver participation is covered, as long as the item is identified within this service definition, determined by the team and appropriate professional to be necessary, and the cost of the repair does not exceed the cost of purchasing a replacement piece of

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify)*:

None

Certificate *(specify)*:

None

DRAFT

Other Standard *(specify):*

The participant and/or legal decision maker along with team members will identify the appropriate environmental modifications within the participant's plan. In addition to identifying the appropriate environmental modifications, the Team determines if the adaptations can be made by family members, i.e. a father building a ramp according to ADA specifications. In those specific circumstances, the participant and/or legal decision maker obtains the specified material from an individual who is enrolled as a vendor with the Fiscal Agent.

The Team will consider the technical and safety requirements of specific environmental modifications when they consider recommending individual vs. agency provider specifications, i.e. installation of a van lift would only be authorized through a vendor authorized by the manufacturer.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDPM

Frequency of Verification:

Prior to modifications

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

NDCC 43-07, NDCC 43-09, NDCC 43-18

Certificate *(specify):*

None

Other Standard *(specify):*

The participant and/or legal decision maker along with team members will identify the appropriate environmental modifications within the participant's plan. The participant and/or legal decision maker obtains the material and finds an appropriate professional who is or will be enrolled with the Fiscal Agent.

As applicable: building permits, Bonded and Licensed to practice profession, enrolled with ND Secretary of State, and in good standing with Workforce Safety. American's with Disabilities Act guidelines will be followed.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDPM

Frequency of Verification:

Prior to Modifications

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Equipment and Supplies

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

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

This service covers purchases of the following which are not covered under the Medicaid State Plan:
(a) devices, controls, or appliances, specified in the participant's plan, that enable participants to increase their ability to perform activities of daily living (i.e. grab bars, portable lifts or lift systems);

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

All equipment and supplies shall meet applicable standards of manufacture, design and installation.

Equipment and Supplies is limited to $20,000 per participant for the duration of waiver. The authorization database tracks the amount authorized and utilized to prevent over expenditure.

Experimental or prohibited treatments are excluded. These include treatments not generally accepted by the medical community as effective and proven, not recognized by professional medical organizations as conforming to accepted medical practice, not approved by FDA or other requisite government body, are in

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **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: Equipment and Supplies

Provider Category:

Agency

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DDPM

Frequency of Verification:

Quarterly or as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Care Option

DRAFT

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Family Care Option will be provided out of the child's home, in another family home meeting the licensing standards for Family or Adult Family Foster Care on a part-time or full-time basis. Family Care Option may be appropriate for eligible waiver participants less than 21 years of age who cannot remain in their natural family home on a full-time basis.

This service focuses on close communication and coordination with families and the school system during the transition period. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue

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

Family Care Option is not available in group residential settings.

Family Care Option is not available when the participant receives Family Care Option III, or Adult Family Foster Care or Residential Habilitation service.

IHS is not available in the Family Care Option setting.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

DRAFT

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

Service Type: Other Service
Service Name: Family Care Option

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Licensed according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

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:

In-Home Supports

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

This service may be accessed to meet the excess care needs related to the participant's disability associated with maintaining a participant in their home and not covered through the Medicaid State Plan. In-Home Supports (IHS) is intended to support the participant and to permit the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement.

In-Home Supports benefits the primary caregiver by assisting the participant in activities of daily living such as eating, drinking, toileting, and physical functioning; improving and maintaining mobility and physical functioning when these tasks require more than one person to accomplish. It may also include assisting the participant with maintaining health and personal safety while the primary caregiver is home and attending to other household tasks and children and no other natural support is available.

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

Hours of support will be limited to 300 per month per participant unless an exception is approved by the DD Division as preventing imminent institutionalization.

Individuals providing IHS may not live in the same home as the participant.

IHS is not authorized when Part B services of IDEA offered through the North Dakota Department of Public Instruction are available to the participant.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Licensed according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

As required by the participants plan. For self-directed service delivery the individual provider must be 18 years or older.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent

Frequency of Verification:

DRAFT

Prior to hiring for verification of age 18

Annually review of the participants plan

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:

Infant Development

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope):*

Infant Development is an individualized service that is delivered on a one to one basis professional to participant.

Infant Development is a home-based, family focused service that provides information, support and training to assist the primary caregiver(s) in maximizing the child's development utilizing a parent-coaching model. Infant Development professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. The title of the participants plan for children under age three and receiving Infant Development services is called the Individualized Family Service Plan (IFSP). This Team determines services necessary to meet the child and caregiver needs, along with the frequency and duration of services.

DRAFT

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

Infant Development serves children birth through 2 years of age as they are not eligible for special education services available for children eligible for Part B-619 of IDEA offered through the North Dakota Department of Public Instruction. This service cannot be accessed at the same time as Part C funded services thru IDEA.

Infant Development does not provide direct therapies nor can it be provided at the same time as other waiver services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Infant Development

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify)*:

Licensed according to NDAC 75-04-01.

Certificate *(specify)*:

Other Standard *(specify)*:

Infant Development programs must provide services according to the prescribed delivery model and cannot offer other models, including direct therapy to infants and toddlers.

The prescribed service delivery model is based on research showing that infants and toddlers do not learn in massed trials, but through natural learning opportunities that occur throughout the day. Infant Development is an individualized service that is delivered on a one to one basis professional to participant. Infant Development professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. The Team determines services necessary to meet the child and caregiver needs, along with the frequency and duration of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

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:

Parenting Support

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Parenting Support assists participants who are or will be parents. Parenting Support is different from family support programs as the eligible individual is the parent. In family support programs the eligible individual is the child.

Parents receive parenting skills training that is individualized and focused on the health and welfare and developmental needs of their child. Close coordination is maintained with informal supports and other formal supports.

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

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

Parenting Support is limited to an average of four hours of individualized child-focused direct training per week during a quarter.

This service is not available if Residential Habilitation is authorized. If the eligible participant (parent) does not have physical custody or visitation rights, they will not receive individualized child-focused training, but group training and support activities are provided.

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

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

DRAFT

☑ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parenting Support

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

According to NDAC 75-04-01. Licensed to provide family support programs or Infant Development

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency, DD Division

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation Costs for Financially Responsible Caregiver

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

Category 2:

17 Other Services

Sub-Category 2:

Category 3:

17 Other Services

Sub-Category 3:

Category 4:

17 Other Services

Sub-Category 4:

Service Definition *(Scope)*:

Funds for this service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to prevent out of home placement of minor children who are living in their primary caregiver's home. Transportation costs for Financially Responsible caregiver include expenses such as mileage, lodging, etc. incurred by family members related to accessing supports identified in the participants plan. Lodging for the participant and/or accompanying caregiver is only allowed when medically necessary or cost effective and the reimbursed amount will not exceed allowed state rates which for out of state travel are based on Medicaid State Plan reimbursement rates. Lodging will not be reimbursed without a receipt.

All associated costs (i.e. mileage, lodging, meals) must be authorized before reimbursement for transportation can occur. The authorization is a part of the participants planning process. The authorization is also approved by the DD Division.

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

Limited to $5,200 per State Fiscal Year per participant.

Out-of-state mileage included in the participant's authorization is determined between the participants dwelling and the city where services are accessed.

In-state mileage through this service is reimbursed after the first 150 miles are incurred in each month.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [x] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

DRAFT

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation Costs for Financially Responsible Caregiver

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vaild Driver's License and required insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent will verify that lodging, meals and mileage does not exceed the amount of the submitted receipts and the total requested does not exceed the amount authorized by the DDPM.

Frequency of Verification:

Annually review of the drivers license and insurance. Fiscal Agent will verify expenditures and provider qualifications per contract requirements.

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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DD Program Management through the Regional Human Service Centers which are under the umbrella of the Department of Human Services.

Appendix C: Participant Services

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

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

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

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

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

As provided by NDAC and DD Division policy, criminal background checks must be conducted on all prospective employees of licensed DD provider agencies who may have direct access to individuals served. This includes direct care positions, administrative positions, and other support positions that have contact with 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.

The DD Division reviews any record of a criminal conviction of an applicant to determine if according to NDAC the individual is eligible to be considered for employment by a licensed DD provider.

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):

DD Division policy 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 Dept. of Human Services Children and Family Services Division. An abuse registry is not maintained specifically for providers of waiver services.

Appendix C: Participant Services

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

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Group Homes	

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

Group homes with four or more beds allow participants to live in residential neighborhoods in the community. Meals are served family style and resident's access community activities, employment, schools or day programs. Per NDAC it is the policy of the state to assure basic human rights to each participant of a facility. These rights include the right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment.

DRAFT

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Infant Development	☐
Residential Habilitation	☑
Transportation Costs for Financially Responsible Caregiver	☐
In-Home Supports	☐
Environmental Modifications	☐
Behavioral Consultation	☐
Adult Day Health	☐
Family Care Option	☐
Homemaker	☐
Parenting Support	☐
Day Supports	☐
Extended Services	☐
Extended Home Health Care	☐
Equipment and Supplies	☐
Adult Family Foster Care	☐

Facility Capacity Limit:

Eight

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑

DRAFT

Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

N/A

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 participant 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.

DRAFT

○ **Other policy.**

Specify:

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

Enrollment is open to all entities that meet the licensure requirements. NDAC details the requirements, application process and appeal rights. Application materials are available on request or on-line.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
(C-1) Number and percent of providers, subject to licensure, meet North Dakota's state law and adhere to other standards prior to furnishing waiver services. N: Number of providers, who met ND's state law and adhered to other standards prior to furnishing waiver services. D: All provider applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Licensed 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

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

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

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

DRAFT

Performance Measure:
(C-2)Number and percent of new self-directed service (SDS) In-Home Support employees, who have met ND State requirements. N: All new SDS In-Home Support employees have met State requirements. D: All new SDS In-Home Support employees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Agent Report

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

Data Aggregation and Analysis:

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

DRAFT

	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-Annually

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

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

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

Performance Measure:
(C-3) Number and percent of family In-Home Support members who report that staff hired meet minimum client specific competencies identified in the participants plan. N: Number of SDS-IHS family members who report that IHS staff hired meet minimum client specific competencies. D: All SDS-IHS participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Web based 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

DRAFT

	☑ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

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

Performance Measure:
(C-4) 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):
Other
If 'Other' is selected, specify:
Provider Monitoring

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

DRAFT

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

Data Aggregation and Analysis:

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

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

All DD providers are required to initially enroll and re-enroll every year. The DD providers are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a DD provider. DD Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment.

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 DD Division is responsible for licensing all DD Providers. Individual provider problems are addressed in writing with the provider and may include one on one technical assistance, requests for additional information, clarification/ rewriting licensing documents and instructions, monitoring and termination of the DD provider who fails to re-license or no longer meet the DD provider standards or qualifications.

The DD Division staff is responsible to address any complaints received. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

ii. Remediation Data Aggregation

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

	Frequency of data aggregation and analysis*(check each*

DRAFT

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

DRAFT

☐ **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 C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Department has done a review and analysis of all settings (residential & nonresidential) where HCB services are provided to eligible clients. The analysis included review of ND Century Code, ND Administrative Code, policy, and review of licensing rules, regulations and documentation.

Through this process the state has determined the following waiver services fully comply with the regulatory requirements because these services are individually provided in the recipient's private residence and allow the client full access to community living. Recipients get to choose what service and supports they want to receive and who provides them. Recipients are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Overall Service Plan (OSP)/Individualized Family Support Plan (IFSP). The State is in the process of moving toward utilizing the title of OSP for all participant plans. However, at this point the current protocol refers to the separate titles for varies service populations (e.g. IFSP for Early Intervention Services/ID services).

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:

The Qualified Developmental Disabilities Professional (QDDP formerly QMRP) is an employee of the state Medicaid agency responsible to authorize the DD waiver services including the amount, frequency and type of provider. This information is contained in the individual service plan section of the overall plan.

Social Worker

☐

Specify qualifications:

☑ **Other**

Specify the individuals and their qualifications:

For Residential, Day Habilitation, Infant Development, In-Home Support, Family Care Option and Parenting Support services staff of DD licensed providers of waiver services is responsible for the person center service planning component and delivery of wavier services.

For self-directed services (Behavior Consult, In-Home Support, Environmental Modification, Equipment & Supplies, and Transportation for Financially Responsible Caregiver, Extended Services), AFFC, Extended Home Health, HM, and Adult Day Health the DDPM is responsible to develop the service plan.

Primary Early Intervention Professionals within the Infant Development provider are responsible to write the Individual Family Service Plan and are all licensed in their profession of early childhood special education, occupational therapy, physical therapy, speech language pathology, social work and nursing.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *Select one:*

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

⊙ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Safeguards to ensure that the participants plan development is conducted in the best interest of the individual are evident when an individual or their legal decision maker chooses a service provider from a list of all qualified providers. A list of qualified providers will be given to the waiver participant and/or their legal decision maker at the time of waiver enrollment and annually thereafter or whenever the participant voices a complaint or concern. The list will be contained in a packet which also includes additional rights of the participant including a rights and responsibilities brochure, contact information for the DDPM, the appeals supervisor (to request a Fair Hearing).

Once an individual or their legal decision maker selects a provider they acknowledge that they made an independent choice when signing the Individual Service Plan (ISP). The right to a choice of service provider is printed at the top of the ISP document along with other participant rights. The plan developed by a

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.

All waiver participants and/or legal decision makers are active participants in the service plan development. The DDPM provides written information to all waiver participants and/or their legal decision maker that describes their right to direct and be actively engaged in the development or the participant plan, including their right to determine who is included in the process. This will be included in the rights packet of information that will also describe the services available, their rights and responsibilities including their right to choose between and among waiver services, service providers and the right to request a Fair Hearing. The DDPM provides this information to the participant and/or legal decision maker at the time of waiver enrollment and whenever a participant signs the ISP. The rights are included at the top of the document.

In addition, a self-assessment, or in the case of infants and toddlers, a routines-based interview is conducted with the participant and/or legal decision maker prior to each annual service plan that identifies personal goals, preferences, and outcomes that may be incorporated into the plan. The participant and/or legal decision maker

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):

(a)Who develops the plan, participants and timing of the plan:

The DDPM or qualified staff from a DD licensed provider assists the participant and/or legal decision maker in identifying the participants they wish to involve in the process of their plan and to determine a date and time that is convenient for the participant in developing the plan.

In addition to the individual, legal decision maker, DDPM and service provider, additional planning team members may include family, friends, advocates and other community supports. Staff members who work most closely with the individual providing direct support and care, and know the individual best are encouraged to

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 initial risk assessment instrument is completed by the DDPM prior to waiver enrollment. When services are selected the risk assessment is reviewed by the team and the strategies to mitigate the identified risks are incorporated into the service plan.

At least annually or as needed, the team reviews the risk assessment as part of the service planning process and develops the strategies to mitigate the identified risks that are incorporated into the service plan.

Through the risk assessment, potential risks are identified, including but not limited to risks related to financial concerns, legal issues, fire safety, falls, access to health care, family issues, informal/community/social supports, mental health/ behavioral health needs, cognitive decision making, nutrition, medication, employment

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The DDPM provides the participant/legal decision maker with a list of qualified service providers upon enrollment in the waiver and upon request. The right to choose their qualified provider(s) is listed at the top of the service plan which is signed by the participant/legal decision maker at least annually or whenever there is a change in services.

The participant may choose to be referred to one provider or multiple providers. The DDPM assists the participant in arranging for interviews of potential providers and touring program sites selected by the participant.

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 DDPM, an employee of the State Medicaid agency, is responsible to ensure that the plan contains all required components (i.e. individual's current status, strengths and support needs, specific outcomes and goals, learning and support objectives, risks and mitigation strategies, health needs, safeguards and financial benefits)and approves all waivered services in the plan.

A sample of the service plans are reviewed by the State DD Division as part of the human service center and provider licensing process.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

DRAFT

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The plan identifies the DDPM who is responsible for the monitoring of the implementation of the service plan and participant health and welfare.

The DDPM has direct oversight of the plan to assure that services are furnished in accordance with the services authorized. The DDPM ensures services meet the participant's needs, back up plans are effective, participants exercise their choice of provider, and access to health services identified in the plan.

The DDPM is responsible to conduct face to face visits with the participant approximately every 90 days in the setting in which the waiver services are delivered. The DDPM reviews progress toward outcomes, determines the participant's satisfaction with services and addresses any concerns.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
(D-1) Number and percent of participant plans that include strategies to address needs and mitigate risks identified through the assessment process. N: Number of participant plans that included strategies to address needs and mitigate risks identified through the assessment process. D: Total number of plans reviewed.

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Interval, +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

Performance Measure:
(D-2) Number and percent of the participant plans are updated annually. N: Number of participant plans updated annually. D: Total number of plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Web based 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
(D-3) Number and percent of participants who receive the services in their plans. N: Number of participants and/or legal decision makers who report they did receive the services in their plan. D: All participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Enhancement Review (QER) through the web based 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

DRAFT

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

Data Aggregation and Analysis:

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

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

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

Performance Measure:
(D-4) Number and percent of participants who have a signed ISP, stating that they have chosen between waiver services and providers. N: Number of participants who have a signed ISP, stating that they have chosen between waiver services and providers. D: All participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual Review (licensure)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Interval, +/-5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

DRAFT

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

The DDPA/DD Division reviews any areas of noncompliance identified in the record review, for the sample. Any areas of noncompliance are addressed by the DDPA, with the respective DDPM and the results will be reviewed with DD Division. Any deficiencies require a corrective action plan within the HSC administrative code. Follow up is completed per DD Division policy.

(D1)The DDPA/DD Division reviews the assessments, in the sample, and ensures that all identified needs and risks are mitigated. The DDPA addresses any unmitigated needs and risks with the respective DDPM. If a participants plan needs to be updated, a Team meeting is held as specified by the DD Division policy. The DDPA verifies that corrections are made.

ii. Remediation Data Aggregation

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

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

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

DRAFT

responsible for its operation.

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Participants determine the vendors/providers from whom they will purchase services and supports. They will also negotiate the cost. Participants will have the opportunity to determine their priorities within the waiver budget limitations. DDPMs and Fiscal Agent staff will 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 will also be offered.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

- [x] **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:

DRAFT

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Self-directed services consist of Behavior Consultation, Environmental Modifications, Equipment and Supplies, and Transportation Costs for the Financially Responsible Caregiver. These services are, solely, participant-directed. In-Home Supports and Extended Services can be either participant-directed or provider managed.

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.

Discussed at intake, prior to enrolling in the waiver, and annually during the team planning process, the DDPM provides the following information to the participant and\or legal decision maker:
a. description of benefits and potential liabilities associated with participant direction of services;
b. responsibilities of participants;
c. support and information available through DDPMs and the Fiscal Agent;
d. components of the participant service plan and their responsibility in its development

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

DRAFT

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
Transportation Costs for Financially Responsible Caregiver	☐	☑
In-Home Supports	☑	☑
Environmental Modifications	☐	☑
Behavioral Consultation	☐	☑
Extended Services	☑	☑
Equipment and Supplies	☐	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**
☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

Contract Entity applying the North Dakota policies for the procurement process.

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

Monthly fee for service

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

DRAFT

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

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

The DD Division has frequent (at least every quarter) conference calls with the Fiscal Agent to review issues identified through data analysis of the QER. 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 DD Division Staff monitor 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 conducted 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.

DRAFT

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

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Infant Development	☐
Residential Habilitation	☐
Transportation Costs for Financially Responsible Caregiver	☐
In-Home Supports	☐
Environmental Modifications	☐
Behavioral Consultation	☐
Adult Day Health	☐
Family Care Option	☐
Homemaker	☐
Parenting Support	☐
Day Supports	☐
Extended Services	☐
Extended Home Health Care	☐
Equipment and Supplies	☐
Adult Family Foster Care	☐

☑ **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:

Qualified Developmental Disability Professionals, employed by the Department of Human Services, at the Regional Human Service Centers, provide program management. This is claimed as an Administrative Activity.

DDPMs meet with the participants and/or legal decision makers to review information regarding the roles, risks, and responsibilities involved with self -directing supports. The DDPMs connect them to the Fiscal Agent, provide practical skills training to assist them with directing services, assist them with locating sources of waiver goods and services and developing budget management skills.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

⦿ **Yes. Independent advocacy is available to participants who direct their services.**

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

The DDPM informs the participant and/or legal decision maker of the availability of representation from the ND Protection and Advocacy Project. If requested, the DDPM will assist participants in accessing services with the ND Protection and Advocacy Project. The availability to contact Protection and Advocacy Project is also printed at the top of the individual service plan that is signed by the participant and/or the legal decision maker. The Protection and Advocacy Project does not furnish other direct services or perform waiver functions.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

DRAFT

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 DDPM reviews the ramifications of voluntary termination, including possible impact on Medicaid and health and safety issues for the eligible participant. Other support options including Medicaid State Plan services and other waivers are explored. The DDPM assists the participant and/or legal representative in transition activities. 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 provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the roles and responsibilities identified in the participants plan are not carried out and it is directly impacting the health and safety of the eligible participant, the DDPM notifies the participant that services are being terminated and review their right to appeal the termination of services offered through this waiver. Other support options including Medicaid State Plan services and other waivers are explored. The DDPM assists the participant in transition activities.

The Participant Agreement and the Budget Authorization for self-directed services describes circumstances under which the services are terminated. Services will be terminated if the parent or legal guardian is unable to self-direct services which results in a situation that jeopardizes the participant's health and welfare, Medicaid fraud, the participant is no longer eligible for Medicaid or ineligible for ICF/IID level of care. Services will continue during the transition unless there are situations that immediately impact the health and safety of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		510
Year 2		535
Year 3		560
Year 4		585
Year 5		610

Appendix E: Participant Direction of Services

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

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

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

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

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

Providers are licensed through the ND Department of Human Services to provide family support services or and Extended Services. Licensed providers are vendors with the Fiscal Agent. To assure individuals/families maintain control and authority over employees, and that the family support service provider supports the concepts of self-direction, specific roles and responsibilities are addressed in the participants plan.

DDPM's are responsible to assist the participant in plan development and ensuring the qualifications for staff are meeting the family's guidelines as described in the plan. Family satisfaction with staff is reviewed at least quarterly.

☑ **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

DRAFT

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*:

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [x] **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:

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

DRAFT

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The Team discusses potential outcomes and service needs for a participant. If self-directed services are recommended, the participant completes the application process. Through the application process generic and informal resources are discussed with the family to determine if there are any natural supports or other community supports available to meet the family's needs which would negate need for waiver services.

Service delivery is dependent upon outcomes identified in the team planning process after family has prioritized need. An application has been developed and is utilized upon entry into waiver service and annually thereafter. The application assists the family in identifying need areas and assists the DDPM in determining the excess

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Participants and/or their legal decision maker signs all individualized authorizations which identifies services and services amounts authorized to indicate their approval of the projected budget and acknowledge their right to appeal. The budget is only authorized after the participants plan is developed.

Quarterly, the DDPM reviews with the participant and /or the legal decision maker if the services continue to meet their needs. If during the authorization period additional funds are needed to ensure the health and safety the participant, the family will request a meeting with their DDPM to renegotiate their budget.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DRAFT

DDPMs inform participants and/or legal decision makers that due to the nature of the program being self-directed; it is the participant's responsibility to utilize their authorized services based on their need. This is discussed prior to service provision.

The Fiscal Agent has an on-line budget balance sheet that indicates total budget, percentage of expenditures and remaining funds. This information is available to the DDPMs and participants. The participants and/or their legal representatives receive the same information as payments are made or on a monthly basis if requested. The fiscal agent provides the participant and/or legal decision maker with a monthly statement showing service utilization. The participant and/or legal decision maker can monitor the monthly statement. Participants and/or their legal representatives may also call the Fiscal Agent for updated information.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

When applicants have expressed interest in services the DDPM meets with them to complete intake activities and explore potential service options. At this time the DDPM also informs them in writing of the grievance procedures which includes their right to a fair hearing.

At the top of each service plan that is signed by the participant and/or legal decision maker the following rights are listed: the right to request 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 of their choice; or whose services are denied, suspended, reduced or terminated. Notification of Rights at a minimum are provided to each waiver participant by the DDPM at enrollment, during the development of the participants annual plan process, and whenever a participant registers a concern regarding services.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The participant and \or legal decision maker may request an informal conference to dispute a denial of services, termination, reduction or suspension of services, choice of provider, and choice of HCBS versus institutional care, The use of informal conference will not preclude or delay the individual's right to a fair hearing.

The request for an informal conference must be submitted to the Regional Human Service Center Director within 10 days after the written notice of the determination. The Center Director shall within five working days of an oral or written request for an informal conference convene a conference with the aggrieved party. Within five working days after the informal conference the Regional HSC Director will issue a written decision.

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).

DRAFT

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

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

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

The definitions for Abuse, Neglect and Exploitation and the role of the Protection and Advocacy Project are defined in North Dakota Century Code 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 Chapter 50-25. l Child Abuse and Neglect. In addition, the Developmental Disabilities Division has developed policies and procedures for entities that provide services to waiver participants regarding the reporting and follow up of Serious Events including abuse, neglect and exploitation. Providers of home and community- based waiver services are required to report serious events and alleged abuse, neglect and exploitation.

All Serious Events (unplanned hospitalization, death, unauthorized restraints, and alleged sexual abuse/contact) are reported to, and assessed by an independent third party. For participants age 18 and older, the Protection and Advocacy Project (P & A) will be responsible to receive the reports, assess the need for further follow up

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.

DD Program Managers provide participants and their legal decision makers with written information regarding the "DD Bill of Rights", ND Century Code 25-01.2 and definitions of abuse, neglect and exploitation. The information will be presented at a level consistent with the individual'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. Individuals who are in need of self-advocacy training per risk assessment receive self-advocacy training as part of their plan.

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.

Upon receipt of the report, P&A or CPS determines if the incident requires follow up by an independent third party. If it is determined that the incident does not meet the criteria for serious event and/or does not require investigation by an independent third party, the service provider conducts an investigation within 5 working days of being informed that it doesn't require an independent investigation and submit their findings to P&A, the Regional DD Program Administrator and the State DD Division. The specific requirements for the investigation are described in DD Division policy.

Upon receipt of the service provider's investigation report, P&A submits a Letter of Findings indicating whether or not the incident is substantiated as abuse, neglect or exploitation and any recommendations for follow up. All investigations and findings are reviewed by DD Division staff.

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 DD Division for serious events and all other incidents reported as abuse, neglect and exploitation are entered into an Incident Management data base maintained by the State DD Division.

In addition, monitoring of all service providers is conducted biannually by State DD Division and P&A staff. The monitoring includes a sample review of incident reports to determine if the service provider is reporting serious events as required, or utilizing the reporting determination guidelines and conducting investigations as indicated in DD Division policy.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

its frequency:

⦿ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All service providers must have written policy and procedures concerning behavior intervention and emergency procedures for controlling maladaptive behavior and must provide for a Behavior Management Committee and Human Rights Committee. The policy and procedures must emphasize positive approaches and define and list techniques that are used and available for use in their relative degree of restriction.

Before highly restrictive emergency procedures can be implemented it is the responsibility of the planning team to perform and document a functional and ecological analysis (analyze the maladaptive behavior to determine the intent of the behavior, the antecedents of the behavior and whether environmental alterations would reduce or eliminate it, or there is a medical cause for the behavior). The maladaptive behaviors should be targeted for reduction and the plan should specify the adaptive behaviors to replace the maladaptive behaviors. Less restrictive methods must be included in the

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The established safeguards and requirements are reviewed by the team including the DDPM during the development of the participants plan. Data is compiled and reviewed at least monthly by the service provider responsible for implementation of the plan. The DDPM will review the use of individual restraints during the Quality Enhancement Review (QER) on a quarterly basis to assure the safeguards and requirements are met and to assure that the approval of the individual/legal decision maker, behavior management committee and the Human Rights Committee is documented. This information is recorded in the QER and any noncompliance or needed follow up regarding the use of restraints are initiated and documented.

The use of all unauthorized restraints (those not written into the individual's plan and approved by the Human Rights Committee and Behavior Management Committee) meet the criteria for a Serious Event and must be verbally reported to the Protection and Advocacy Project within 24 hours and a

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

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

⦿ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The use of aversive methods or conditioning such as application of startling, unpleasant or painful consequences is prohibited. Designated Time Out rooms are not utilized, although the use of a quiet area or an individual's private bedroom may be used for the purpose of providing the individual an opportunity to regain self-control.

The procedures for behavioral intervention should be an improvement in quality of life for the individual and should not substitute for procedures to provide positive behavioral supports. Behavior plan development includes a functional and ecological assessment, efforts to use least restrictive methods, identification of the specific problem/target behavior to be decreased and replacement behavior to be increased. Staff must be trained prior to implementation of the plan.

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:

Providers are required to submit an annual report to the DD Division identifying participants who have restrictive interventions in the participant's service plan.

Reviews of data are compiled and reviewed at least quarterly by the service provider responsible for implementation of the plan. The DDPM reviews the use of individual restrictive interventions during the Quality Enhancement Review (QER) to assure the safeguards and requirements are met and to assure that the approval of the individual/legal decision maker, behavior management committee and the Human Rights Committee is documented. This information is recorded in the QER and any noncompliance or needed follow up regarding the use of restrictive interventions are initiated and documented.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

DRAFT

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

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

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Individuals living in facilities or served by residential programs operated by a licensed provider:

The Developmental Disabilities Division (DD Division) through the licensing process, reviews provider policies and procedures for compliance with North Dakota Century Code (NDCC) and North Dakota Administrative Code (NDAC) regarding access to medical services and medication administration. License renewal is conducted annually for each licensed provider. Per DD Division policy a licensed provider serving non-self-medicating persons must develop written procedures approved by a licensed medical practitioner for maintaining, retrieving, and controlling access to medication.

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.

The DD Division maintains the statewide medication administration training program. Licensed nurses train personnel utilizing the ND state curricula and practica to certify individuals who have successfully completed training.

Medication errors that meet reporting determination guidelines as noted in G-1 above must be investigated and reported to the DD Division and P & A. Practices or conditions that suggest systemic issues with a providers medication administration practices must be addressed with a plan of remediation approved by the DD Division and P&A. Reported medication errors are included in a statewide abuse, neglect, and exploitation (A,N,& E) database to allow determination of trends.

Appendix G: Participant Safeguards

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

c. **Medication Administration by Waiver Providers**

i. **Provider Administration of Medications.** *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

⦿ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DD Division through the licensing process reviews provider policies and procedures for compliance with NDCC and NDAC access to medical services and medication administration. License renewal is conducted annually for each licensed provider.

The DD Division maintains a state wide training program currently being implemented through a contracted entity. This entity maintains a record of personnel and training which is provided to the DD Division upon request.

DD Division policy requires that non-licensed personnel administering medications to complete the medication administration module of the ND staff training system and that medication administration is delegated by a licensed medical professional. Periodic review for those personnel is conducted to determine

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:

Medication errors that meet the reporting determination guidelines are reported to DD Administrators, Protection and Advocacy Project, and the DD Division.

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

Licensed DD Providers are required to record all medication errors in the incident management reporting system. The types of errors recorded are as follows: a) wrong person, b) wrong medication, c) wrong dose, d) wrong time e) wrong route, f) wrong documentation, and g) missing a controlled substance.

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

Medication errors meeting the reporting determination guidelines are assessed by a third party for a determination of investigation or follow-up. The following is the criteria for reporting determination:

1. A medication was not administered according to doctor's orders and the participant was harmed or placed at risk of harm (including having to repeat medical treatment or medication).
2. A medical procedure was not administered or completed according to doctor's orders and the participant was harmed or placed at risk of harm.
3. A controlled substance is missing

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DD Division has the oversight responsibility for monitoring the performance of waiver providers in the administration of medications to waiver participants.

Medication errors that meet reporting determination guidelines as noted above must be documented in the web based data system. Further investigation and follow-up is determined by the DD Division and P & A. Practices or conditions that suggest systemic issues with a providers medication administration practices must be addressed with a plan of remediation approved by the Division and P&A. Reported medication errors are included in a statewide A,N,& E database to allow determination of trends.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
(G-1) Number and percent of participants who have a signed ISP, stating that they have been informed of their rights, including the right to be free of A, N and E and reporting procedures. N: Number of participants who have a signed ISP, stating that they have been informed of their rights, including the right to be free of A, N, and E and reporting procedures. D: All ISPs reviewed from sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Interval, +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

DRAFT

Data Aggregation and Analysis:

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

Performance Measure:
(G-2)Number and percent of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number of assessments where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. D: All assessments that are substantiated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracking system (PSI 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

DRAFT

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracking system(PSI) and web based 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

DRAFT

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

Data Aggregation and Analysis:

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

Performance Measure:
(G-4) Number and percent of substantiated choking incidents for waiver participants. N: Number of choking incidents substantiated through investigation where follow up was required. D: The total number of choking incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual review and web based 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):*

DRAFT

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

DRAFT

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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.

To verify the accuracy of data, the number and percent of incidents that are correctly identified as reportable by providers, will be reviewed during biennial abuse, neglect, and exploitation training and monitoring by DD Division and P & A staff. Stratified samples by service type will be reviewed.

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.

DDPMs will review incident investigations and implementation of recommendations to prevent reoccurrence. Unresolved issues related to implementation will be reported to the Provider to develop a corrective action plan. If the issue cannot be resolved at this level, the DDPM will inform the DDPA and the DD Division for impact on licensure.

Quarterly meetings are held with the P & A to address review of incident report trends, training activities, incident report system policies and procedures, and results of reviews of provider internal incident practices.

ii. Remediation Data Aggregation

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

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

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

The DD Division is investigating options to utilize the web-based application to facilitate more timely reporting and accurate collection of data for adding information to the QER for performance measure G-2, G-3, and for performance measure G-4 determining to have trained all DD providers to put the information into the web based data system correctly. Anticipated date for implementation for performance measures G-2, G-3, and G-4 is March 31, 2015.

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.

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

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

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and

remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's 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 QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 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 DD Division is responsible for evaluating the effectiveness and outcomes of the discovery, remediation, and quality improvement plans. The Division prioritizes its remediation efforts to address any problems that involve client care or health and welfare issues first. The Division keeps track of its quality improvement efforts by maintaining databases and statistics that include applicable time frames for completion. The Division uses this information to make necessary changes to improve quality.

When pre-determined performance measures are not met or problems (that are not directly related to participant care or health welfare and safety issues) are identified, DD discusses the issue(s) at meetings and develops a plan of action. The action plan is documented and may include, providing information to DDPA's and DDPM's addressing updated policy/protocol as needed. If the problem involves client care or health welfare and safety issues the problem is addressed immediately. Policy is updated as needed.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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 DD Division monitors system design changes and discusses at meetings the need for changes. The DD Division maintains a quality assurance plan that describes system improvements and other remediation efforts. The DD Division keeps track of identified problems and tracks the number of errors that are identified over time. If no improvement is seen new strategies are put in place.

Quality improvement strategies are discussed monthly with DD Division staff and at least annually with other stake holders. Other stake holders may include but are not limited to P & A, Health Facilities, DD Provider association, Money Follows the Person Program Director, the Long Term Care Program Administrator, the Mental Health Program Administrator, and the Assistant Medical Services Director.

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

The DD Division will evaluate the quality improvement strategies once during the waiver period and prior to renewal of the waiver.

The results of the analysis are shared with various stakeholders\entities to determine appropriate revisions, prioritization, and changes in mitigation strategies.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

DRAFT

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).

An allowable cost-based retrospective rate setting system is utilized. Annually, provider's actual costs and revenue are audited by the DHS Provider Audit Unit. In order to be eligible for reimbursement, the provider must participate in the program audit and utilization review process established by the department. Providers under contract with the department to provide services to individuals with developmental disabilities must submit to the department, no less than annually, a statement of actual costs. Providers must disclose all costs and all revenues. Providers must identify income to offset costs when applicable in order that state financial participation not supplant or duplicate other funding sources. The final rate established per the program audit review process is payment for all allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to eligible clients subject to limitations and cost offsets per North Dakota Administrative Code 75-04-05. The audits include review of reported costs to determine that they are allowable according to the rules. Final rates are then determined by census data, revenue, and allowable costs. The audit is then settled with payback by the provider if payments exceed allowable costs. The process, allowable and non-allowable cost definitions, and accounting requirements are set out in North Dakota Administrative Code Chapter (NDAC) 75-04-05 and Purchase of Service requirements in NDAC 75-04-02.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
(I-1) Number and percent of Traditional waiver service claims that paid out at the authorized amount. N: Number of Traditional waiver service claims that paid out at the authorized amount. D: Total number of claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Payment System

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual Review of final rate determination and final computation of settlement

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

DRAFT

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

DRAFT

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

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

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.

(I-1) Samples are not pulled for review as ALL claims that do not pass edits built into the system are suspended within MMIS. 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 advise with a code indicating the cause of the suspension. The provider and DDPM work together to correct the billing error.

During the provider audit process, if non-allowable costs are identified in the cost report, the costs are disallowed in the final rate determination.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

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

DRAFT

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 rates are primarily determined by the collective need (amount of services) of the individuals in the program, salary and fringe costs, and administration (fixed/operating costs). Retrospective rate-setting requires that an interim rate be established prior to the year in which it will be effective. Providers are required to submit a statement of budgeted costs to the department no less than annually so an interim rate may be determined. The determination of a final rate for all services begins with the reported cost of the provider's operations for that fiscal year. Once it has been determined that reported costs are allowable, reasonable, and client-related, those costs are compared to the reimbursements received through the interim rate. Settlements are made through a recoupment or refund to the department for an overpayment or an additional payment to the provider for an underpayment.

The approved level of DD participation for administrative and general client salaries will be determined from base year audited costs, plus adjustments for legislatively approved inflationary and/or hourly wage increases. The approved level of DD participation for direct service salaries is based on established hourly wage

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:

Billings flow directly from the provider of the service to the State's claim payment system for all services except self-directed services. In self-directed services, participants direct bills or invoices to the fiscal agent. The fiscal agent pays the vendor or reimburses the participant, codes the claims as to specific type, and bills through the state claims payment system.

Appendix I: Financial Accountability

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

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

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

***Select at least one*:**

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

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

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

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

Appendix I: Financial Accountability

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

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

DRAFT

DDPMs determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). DDPMs then authorize services on the Individual Service Plan in the web based data system. Edits are not built into the MMIS system to prevent payment for services not authorized. However, the subsequent checks described (numbered 1-7) are in place to assure services are received as billed.

The DD Claims reviewer receives weekly queries of the web based data system for individual changes to Level of Care and start or termination of waivered services. The ICF/IID Level of Care determinations are entered into an MMIS file. The Individual Service Plan information authorizing a waiver service is entered into a DD eligibility file which includes the service authorized, dates for which authorized, provider number and Medicaid number and rate and frequency.

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:

(a) Waiver services that may qualify for the difficulty of care payments are for Residential Habilitation, Day Habilitation, Extended Services, provider managed In-Home Supports and Family Care Option III.

(b) The Department enters into a contract with each licensed DD Provider agency that provides services for those participants who qualify for the difficulty of care payment dollar amounts for the identified participants.

(c) Annually, the providers' actual costs and revenue are audited by the DHS Provider Audit Unit. In order for the provider to be eligible for difficulty of care payments the provider must participate in the program audit and utilization review process established by the Department. The provider must

○ **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 or reimburses the participant, codes the claims as to specific type, and bills through the state claims payment system. On-line accounts are available for participants, the DDPM monitors, individual budgets, and account balances. Quarterly reports of the fiscal agent are available to the DD Division.

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

DRAFT

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:

Two of the Department of Human Services Regional Human Service Centers and the Life Skills and Transition Center (State operated facility) provides direct services to waiver participants. Rates are based on actual costs. Services provided are Day Supports, Extended Services and ISLA.

A number of county social service boards are providers of Homemaker Services. Rates are set in the same manner as for all agency providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- (●) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments)**

DRAFT

that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

DRAFT

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

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

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

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

Appendix I: Financial Accountability

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

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

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

Check each that applies:

Appropriation of Local Government Revenues.

☐

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

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

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

Appendix I: Financial Accountability

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

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

- ⦿ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ○ **The following source(s) are used**

  Check each that applies:

  - ☐ **Health care-related taxes or fees**
  - ☐ **Provider-related donations**
  - ☐ **Federal funds**

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

Appendix I: Financial Accountability

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

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

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

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

Room and board rates are established by providers according to the provisions of NDAC 75-04-05. Those costs are not allowable in costs claimed by the provider for waiver services. The provider collects the room and board costs directly from individuals receiving services.

Appendix I: Financial Accountability

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

DRAFT

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

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

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

Appendix I: Financial Accountability

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

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

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

i. Co-Pay Arrangement.

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

DRAFT

iii. Amount of Co-Pay Charges for Waiver Services.

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	34863.97	5317.35	40181.32	119996.30	3905.31	123901.61	83720.29
2	38452.43	5530.05	43982.48	124796.15	4061.52	128857.67	84875.19
3	44110.83	5751.25	49862.08	129787.99	4223.98	134011.97	84149.89
4	47033.75	5981.30	53015.05	134979.51	4392.94	139372.45	86357.40
5	50029.12	6220.55	56249.67	140378.69	4568.66	144947.35	88697.68

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

DRAFT

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	**5260**	5260
Year 2	**5365**	5365
Year 3	**4870**	4870
Year 4	**4975**	4975
Year 5	**5080**	5080

Appendix J: Cost Neutrality Demonstration

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

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

Data from the most recent 372 that was submitted to CMS on 09/30/2013 was used to calculate and combined and the estimate for average length of stay is 310.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The number of users estimated for waiver year (WY) 1 is based off of a combination of various data sources including state fiscal year (SFY) 2013 spend downs, CMS 372 reports for WY1, WY2, and WY 3, and the 13/15 biennium budget. The SFY 2013 spend downs and the CMS 372 reports for WY1, WY2, and WY3 are reports that show the actual current expenditures and utilization for waiver services. The 13/15 biennium budget was developed based off of actual expenditures and utilization from the 11/13 biennium and increased for legislatively approved increases. The increase in the utilization was determined by average increases over the current WY1 through WY5.

Average costs per unit consists of:

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is determined by using the 372 Annual Report on HCBS waiver expenditures submitted to CMS on 09/30/13 showing expenditures for 04/01/11 to 03/31/12 an inflationary increase of 3% for the year 2013 and 3% additional increase for the waiver year (WY) WY1. For WY2 through WY5 the rate is increased by 4% inflation based on historic Legislative rate increases.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

A state generated report is used to calculate the G factor. The G factor is based on the current average Medicaid costs for hospital, NF, or ICF/IID services for those individuals eligible for the HCBS waiver minus the average ICF/IID recipient liability, this amount is inflated by 3% for the year 2012 and an additional increase for the waiver year 2013 due to legislation intent. The amount is inflated by 3% for WY1 and 4% WY2-WY5 which is based on historical inflationary rate increases given to ICF's/IID through the legislative process.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

A state generated report is used to calculate the G' factor. The G' factor is the average cost of other Medicaid services that are not included in Factor G. This amount is inflated by 4% for WY1-WY5 based on historical inflationary rate increases given to ICF's/IID through the Legislative process.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	

DRAFT

Adult Day Health	
Day Supports	
Extended Services	
Homemaker	
Residential Habilitation	
Extended Home Health Care	
Adult Family Foster Care	
Behavioral Consultation	
Environmental Modifications	
Equipment and Supplies	
Family Care Option	
In-Home Supports	
Infant Development	
Parenting Support	
Transportation Costs for Financially Responsible Caregiver	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**10058.28**
Adult Day Health	1/2 day	2	158.00	31.83	**10058.28**	
Day Supports Total:						**52111836.00**
Day Supports	hour	1295	1840.00	21.87	**52111836.00**	
Extended Services Total:						**3732960.00**
Extended Services	hour	330	320.00	35.35	**3732960.00**	
Homemaker Total:						**35321.00**
Homemaker	15 minute	11	650.00	4.94	**35321.00**	
Residential Habilitation Total:						**96671257.20**
Transitional Community Living Facility	day	159	360.00	216.05	**12366702.00**	
Individualized Supported Living Arrangement	day	884	360.00	180.62	**57480508.80**	
Supported Living Arrangement	day	120	360.00	14.38	**621216.00**	
Minimally Supervised Living Arrangements	day	245	360.00	235.14	**20739348.00**	
Family Care Option III					**2883254.40**	

	day	24	360.00	333.71		
Congregate Care	day	42	360.00	170.65	**2580228.00**	
Extended Home Health Care Total:						**1182675.40**
Extended Home Health Care	hour	10	2251.00	52.54	**1182675.40**	
Adult Family Foster Care Total:						**681462.00**
Adult Family Foster Care	day	30	340.00	66.81	**681462.00**	
Behavioral Consultation Total:						**255268.26**
Behavioral Consultation	hour	54	13.00	363.63	**255268.26**	
Environmental Modifications Total:						**155848.00**
Environmental Modifications	item	44	4.00	885.50	**155848.00**	
Equipment and Supplies Total:						**584059.68**
Equipment and Supplies	item	383	3.20	476.55	**584059.68**	
Family Care Option Total:						**345844.80**
Family Care Option	day	14	282.00	87.60	**345844.80**	
In-Home Supports Total:						**15265848.94**
In-Home Supports	hour	794	569.00	33.79	**15265848.94**	
Infant Development Total:						**11432821.81**
IFSP/IFSP Review	IFSP	2176	3.00	448.05	**2924870.40**	
Evaluations/Assessments	evaluations	2783	1.00	462.47	**1287054.01**	
Consultations	consultations	1786	4.00	281.19	**2008821.36**	
Home Visits	Home Visits	1073	36.00	134.93	**5212076.04**	
Parenting Support Total:						**87313.36**
Parenting Support	hour	17	152.00	33.79	**87313.36**	
Transportation Costs for Financially Responsible Caregiver Total:						**831900.30**
Out of State	trip	231	5.00	487.99	**563628.45**	
In State	trip	231	5.00	232.27	**268271.85**	
				GRAND TOTAL:		**183384475.03**
				Total Estimated Unduplicated Participants:		**5260**
				Factor D (Divide total by number of participants):		**34863.97**
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

DRAFT

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**10592.00**
Adult Day Health	1/2 day	2	160.00	33.10	**10592.00**	
Day Supports Total:						**59038497.60**
Day Supports	hour	1411	1840.00	22.74	**59038497.60**	
Extended Services Total:						**4070067.20**
Extended Services	hour	346	320.00	36.76	**4070067.20**	
Homemaker Total:						**40092.00**
Homemaker	15 minute	12	650.00	5.14	**40092.00**	
Residential Habilitation Total:						**108369136.80**
Transitional Community Living Facility	day	163	360.00	224.69	**13184809.20**	
Individualized Supported Living Arrangement	day	975	360.00	187.84	**65931840.00**	
Supported Living Arrangement	day	129	360.00	14.96	**694742.40**	
Minimally Supervised Living Arrangements	day	257	360.00	244.55	**22625766.00**	
Family Care Option III	day	26	360.00	347.06	**3248481.60**	
Congregate Care	day	42	360.00	177.48	**2683497.60**	
Extended Home Health Care Total:						**1352941.04**
Extended Home Health Care	hour	11	2251.00	54.64	**1352941.04**	
Adult Family Foster Care Total:						**755942.40**
Adult Family Foster Care	day	32	340.00	69.48	**755942.40**	
Behavioral Consultation Total:						**309729.42**
Behavioral Consultation	hour	63	13.00	378.18	**309729.42**	
Environmental Modifications Total:						**191551.36**
Environmental Modifications	item	52	4.00	920.92	**191551.36**	
Equipment and Supplies Total:						**656584.13**
Equipment and Supplies	item	414	3.20	495.61	**656584.13**	
Family Care Option Total:						**411043.20**
Family Care Option					**411043.20**	

DRAFT

	day	16	282.00	91.10		
In-Home Supports Total:						**17425926.00**
In-Home Supports	hour	855	580.00	35.14	**17425926.00**	
Infant Development Total:						**12666428.03**
IFSP/IFSP Review	IFSP	2273	3.00	465.97	**3177449.43**	
Evaluations/Assessments	day	2924	1.00	480.97	**1406356.28**	
Consultations	consultations	1874	4.00	292.44	**2192130.24**	
Home Visits	Home Visits	1166	36.00	140.33	**5890492.08**	
Parenting Support Total:						**96143.04**
Parenting Support	1 hour	18	152.00	35.14	**96143.04**	
Transportation Costs for Financially Responsible Caregiver Total:						**902629.35**
Out of State	trip	241	5.00	507.51	**611549.55**	
In State	trip	241	5.00	241.56	**291079.80**	
				GRAND TOTAL:		**206297303.57**
				Total Estimated Unduplicated Participants:		**5365**
				Factor D (Divide total by number of participants):		**38452.43**
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**11152.08**
Adult Day Health	1/2 day	2	162.00	34.42	**11152.08**	
Day Supports Total:						**61575140.00**
Day Supports	hour	1415	1840.00	23.65	**61575140.00**	
Extended Services Total:						**4428563.20**
Extended Services	hour	362	320.00	38.23	**4428563.20**	
Homemaker Total:						**45207.50**
Homemaker	15 minute	13	650.00	5.35	**45207.50**	

DRAFT

Residential Habilitation Total:						**112701909.60**
Transitional Community Living Facility	day	167	360.00	233.68	**14048841.60**	
Individualized Supported Living Arrangement	day	971	360.00	195.35	**68286546.00**	
Supported Living Arrangement	day	138	360.00	15.56	**773020.80**	
Minimally Supervised Living Arrangements	day	253	360.00	254.33	**23164376.40**	
Family Care Option III	day	28	360.00	360.94	**3638275.20**	
Congregate Care	day	42	360.00	184.58	**2790849.60**	
Extended Home Health Care Total:						**1535091.96**
Extended Home Health Care	hour	12	2251.00	56.83	**1535091.96**	
Adult Family Foster Care Total:						**835325.60**
Adult Family Foster Care	day	34	340.00	72.26	**835325.60**	
Behavioral Consultation Total:						**368138.16**
Behavioral Consultation	hour	72	13.00	393.31	**368138.16**	
Environmental Modifications Total:						**229862.40**
Environmental Modifications	item	60	4.00	957.76	**229862.40**	
Equipment and Supplies Total:						**733972.32**
Equipment and Supplies	item	445	3.20	515.43	**733972.32**	
Family Care Option Total:						**480900.24**
Family Care Option	day	18	282.00	94.74	**480900.24**	
In-Home Supports Total:						**18533700.90**
In-Home Supports	hour	858	591.00	36.55	**18533700.90**	
Infant Development Total:						**12257563.38**
IFSP/IFSP Review	IFSP/IFSP Review	2085	3.00	484.61	**3031235.55**	
Evaluations/Assessments	Evaluations/Assessments	2595	1.00	500.21	**1298044.95**	
Consultations	Consultations	1719	4.00	304.14	**2091266.64**	
Home Visits	Home Visits	1111	36.00	145.94	**5837016.24**	
Parenting Support Total:						**105556.40**
Parenting Support	1 hour	19	152.00	36.55	**105556.40**	
Transportation Costs for Financially Responsible Caregiver Total:						**977682.65**
Out of State	trip	251	5.00	527.81	**662401.55**	
In State	trip	251	5.00	251.22	**315281.10**	

DRAFT

GRAND TOTAL:	**214819766.39**
Total Estimated Unduplicated Participants:	**4870**
Factor D (Divide total by number of participants):	**44110.83**
Average Length of Stay on the Waiver:	310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**11742.40**
Adult Day Health	1/2 day	2	164.00	35.80	**11742.40**	
Day Supports Total:						**67307568.00**
Day Supports	hour	1487	1840.00	24.60	**67307568.00**	
Extended Services Total:						**4809369.60**
Extended Services	hour	378	320.00	39.76	**4809369.60**	
Homemaker Total:						**50596.00**
Homemaker	15 minute	14	650.00	5.56	**50596.00**	
Residential Habilitation Total:						**122182318.80**
Transitional Community Living Facility	day	171	360.00	243.03	**14960926.80**	
Individualized Supported Living Arrangement	day	1022	360.00	203.16	**74746627.20**	
Supported Living Arrangement	day	147	360.00	16.18	**856245.60**	
Minimally Supervised Living Arrangements	day	259	360.00	264.50	**24661980.00**	
Family Care Option III	day	30	360.00	375.38	**4054104.00**	
Congregate Care	day	42	360.00	191.96	**2902435.20**	
Extended Home Health Care Total:						**1729443.30**
Extended Home Health Care	hour	13	2251.00	59.10	**1729443.30**	
Adult Family Foster Care Total:						**919836.00**
Adult Family Foster Care	day	36	340.00	75.15	**919836.00**	
Behavioral Consultation Total:						**430719.12**
Behavioral Consultation	hour	81	13.00	409.04	**430719.12**	
Environmental Modifications						

DRAFT

Total:						**270931.04**
Environmental Modifications	item	68	4.00	996.07	**270931.04**	
Equipment and Supplies Total:						**816511.36**
Equipment and Supplies	item	476	3.20	536.05	**816511.36**	
Family Care Option Total:						**555709.20**
Family Care Option	day	20	282.00	98.53	**555709.20**	
In-Home Supports Total:						**20502289.92**
In-Home Supports	hour	896	602.00	38.01	**20502289.92**	
Infant Development Total:						**13233001.05**
IFSP/IFSP Review	IFSP/IFSP Review	2157	3.00	503.99	**3261319.29**	
Evaluations/Assessments	Evaluations/Assesments	2736	1.00	520.22	**1423321.92**	
Consultations	Consultations	1764	4.00	316.31	**2231883.36**	
Home Visits	Home Visits	1156	36.00	151.78	**6316476.48**	
Parenting Support Total:						**115550.40**
Parenting Support	1 hour	20	152.00	38.01	**115550.40**	
Transportation Costs for Financially Responsible Caregiver Total:						**1057297.95**
Out of State	trip	261	5.00	548.92	**716340.60**	
In State	trip	261	5.00	261.27	**340957.35**	
				GRAND TOTAL:		**233992884.14**
				Total Estimated Unduplicated Participants:		**4975**
				Factor D (Divide total by number of participants):		**47033.75**
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**12360.36**
Adult Day Health	1/2 day	2	166.00	37.23	**12360.36**	
Day Supports Total:						**73518966.40**

DRAFT

Day Supports	hour	1562	1840.00	25.58	**73518966.40**	
Extended Services Total:						**5213408.00**
Extended Services	hour	394	320.00	41.35	**5213408.00**	
Homemaker Total:						**56355.00**
Homemaker	15 minute	15	650.00	5.78	**56355.00**	
Residential Habilitation Total:						**131880160.80**
Transitional Community Living Facility	day	171	360.00	252.75	**15559290.00**	
Individualized Supported Living Arrangement	day	1073	360.00	211.29	**81617101.20**	
Supported Living Arrangement	day	156	360.00	16.83	**945172.80**	
Minimally Supervised Living Arrangements	day	265	360.00	275.08	**26242632.00**	
Family Care Option III	day	32	360.00	390.40	**4497408.00**	
Congregate Care	day	42	360.00	199.64	**3018556.80**	
Extended Home Health Care Total:						**1936850.44**
Extended Home Health Care	hour	14	2251.00	61.46	**1936850.44**	
Adult Family Foster Care Total:						**1009827.20**
Adult Family Foster Care	day	38	340.00	78.16	**1009827.20**	
Behavioral Consultation Total:						**497718.00**
Behavioral Consultation	hour	90	13.00	425.40	**497718.00**	
Environmental Modifications Total:						**314916.64**
Environmental Modifications	item	76	4.00	1035.91	**314916.64**	
Equipment and Supplies Total:						**904471.78**
Equipment and Supplies	item	507	3.20	557.49	**904471.78**	
Family Care Option Total:						**635723.88**
Family Care Option	day	22	282.00	102.47	**635723.88**	
In-Home Supports Total:						**22632585.26**
In-Home Supports	hour	934	613.00	39.53	**22632585.26**	
Infant Development Total:						**14266691.52**
IFSP/IFSP Review	IFSP/IFSP Review	2229	3.00	524.15	**3504991.05**	
Evaluations/Assessments	Evaluations/Assessments	2877	1.00	541.03	**1556543.31**	
Consultations	Consultations	1809	4.00	328.96	**2380354.56**	
Home Visits	Home Visits	1201	36.00	157.85	**6824802.60**	

DRAFT

Parenting Support Total:						**126179.76**
Parenting Support	1 hour	21	152.00	39.53	**126179.76**	
Transportation Costs for Financially Responsible Caregiver Total:						**1141723.00**
Out of State	trip	271	5.00	570.88	**773542.40**	
In State	trip	271	5.00	271.72	**368180.60**	
					GRAND TOTAL:	**254147938.04**
					Total Estimated Unduplicated Participants:	**5080**
					Factor D (Divide total by number of participants):	**50029.12**
					Average Length of Stay on the Waiver:	310

DRAFT