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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

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

Updates include:

In order to provide culturally competent services, renewal allows the State Medicaid agency to enroll Tribal Nations to provide both case management and direct waiver services to eligible Tribal members. The State Medicaid agency allows entities to provide both case management and direct waiver services only when no other willing and qualified providers are available to provide culturally competent services as a safeguard for potential clients who are eligible Tribal members where access to culturally competent qualified providers is an issue.

Provide a description of the state's Electronic Visit Verification (EVV) system, services impacted, and planned effective date in the financial management section of the waiver. The amendment will also make changes to the rate methodology for Non-Medical Transportation to facilitate the implementation of EVV for this waiver service. To comply with the EVV requirements of the 21st Century Cures Act and implement the Fair labor standards act (FLSA)in-home care final rule the state Medicaid agency has chosen Therap LLC. as the state EVV provider. The estimated EVV go live date is 1-1-2021. The following waiver services are subject to EVV: attendant care (including nurse management). In addition, individual QSPs who provide non-medical transportation will use EVV to track data used to comply with the Fair Labor Standards Act In-home Final Rule.

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*):

Technology Dependent Medicaid Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Draft ID: **ND.016.01.00**

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

Regular Waiver

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

01/19/21

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

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §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.

Purpose:The Technology Dependent Medicaid Waiver provides service options for individual who are ventilator dependent for a minimum of 20 hours per day to maintain in the least restrictive environment.

Goals and Objectives:The goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. In order to successfully meet the mandate, a consumer-centered, affordable delivery system has been established for delivery of in-home services to individuals who are ventilator dependent.

A system has been established to assess the needs of consumers, implement a care plan, monitor the progress of the care plan, and re-evaluate consumer needs on a regular basis.

Partnerships:This system involves a partnership between the local Human Service Zones, the North Dakota Department of Human Services, informal networks, and consumers/family members. Advocates for consumers have played a significant role in identifying the need to develop services for individuals who are technology dependent.

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

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

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

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

The case management entities that provide services are HCBS Case Managers employed by ND Department of Human Services throughout 19 zones across the state and two independent case management agencies. Any other case management agencies or individuals who meet the minimum provider requirements are eligible to provide case management services. QSP enrollment books are available on the Department of Human Services website. Interested parties may also request a copy of the enrollment book directly from the Department of Human Services. Technical assistance is provided upon request.

The North Dakota Department of Human Services, Aging Services Division which is part of the State Medicaid Agency will administer the Waiver.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

H. Quality 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:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

On 09/8/2020 the Medicaid Medical Advisory Committee and the Tribal Consultation Committee members were notified of the State Medicaid Agency's intent to amend the HCBS waiver during their quarterly meetings.

On 09/18/2020 the Department sent a notice to all Tribal Chairman, Tribal Health Directors and Indian Health Service Representatives in North Dakota notifying them of the State Medicaid Agency's intent to amend the Technology Dependent waiver to change waiver oversight authority from the Medical Services to Aging Services Division. Tribal organizations were notified that they could view the waiver on the Department's website or receive a copy upon request. The tribal consultation notification letter was also posted to the Department's website.

In addition, the required 30 day public comment period is being provided. Public comment will be accepted from September 18, 2020 – October 17, 2020. The Department provides opportunities for public comment on the amendment in the following manner: 1) The amendment and accompanying public notice was posted to the Departments website at http://www.nd.gov/dhs/services/medicalserv/medicaid/archives/news-info.html 2) A press release was issued Statewide notifying the public of the opportunity for public comment. The public notice and Statewide press release included information on how to access the waiver application online or request a hard copy and contained information on how to submit public comments.

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

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

7. Contact Person(s)

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

Last Name: Nikolas

First Name: Maier

Title: Director

Agency: ND DHS Aging Services Division

Address: 1237 West Divide Avenure Suite #6

Address 2:

City: Bismarck

State: **North Dakota**

Zip: 58501

Phone:

(701) 328-4607 **Ext:** ☐ **TTY**

Fax:

(701) 328-8947

E-mail:

nmaier@nd.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Dakota**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Knapp

First Name: Caprice

Title: Director

Agency: Medical Services Division

Address: 600 E Boulevard Ave Dept 325

Address 2:

City: Bismarck

State: **North Dakota**

Zip: 58505

Phone: (701) 328-1603 **Ext:** ☐ **TTY**

Fax: (701) 328-2173

E-mail: cknapp@nd.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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.
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.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the State’s most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

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

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

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

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

The waiver specific transition plan aligns with the most recent Statewide Transition Plan that received initial approval of the systemic assessment.

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

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

Appendix A: Waiver Administration and Operation

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.

Aging Services 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 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 Aging Services and Medical Services Divisions. Aging Services 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 other Divisions 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.:*

The Department maintains a contract with Maximum (formerly Ascend Management Innovation LLC) to complete skilled nursing facility level of care determinations that ensure eligibility criteria are met for waiver participants.

○ **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:

HCBS Case Managers perform waiver functions at the local level.
The functions performed by the HCBS Case Managers include:
a) Provide information designed to educate people about the availability and services of the HCBS Medicaid waiver programs;
b) Determine eligibility for, and assist individuals in applying for, Medicaid HCBS waiver benefits;
c) Make Qualified Service Provider lists available to Medicaid recipients so that they may exercise free choice of providers to the greatest extent possible;
d) Follow all rules, policies, and direction of the Department in administering the Medicaid HCBS waiver programs; and
e) Determine level of services to be approved against the limits of the programs.

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

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

Appendix A: Waiver Administration and Operation

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

Aging Services and Medical Services Divisions, North Dakota Department of Human Services

Appendix A: Waiver Administration and Operation

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

The State provides oversight to assure that these functions are being carried out according to Federal and State policy in the following ways:

HCBS Case Managers are reviewed every year, either on-site or via desk audit. Both on-site and desk reviews use the same review guide to evaluate compliance with policy. On-site reviews differ from desk reviews because HCBS Case Managers are unaware of the files that will be chosen prior to the review and include client visits, an exit interview, and the provision of technical assistance as it pertains to the review findings.

Maximus formerly (Ascend Management Innovations, LLC.)is monitored by daily reporting via web application, monthly reports from Maximus to the State Medicaid agency, input from HCBS Case Managers regarding service performance, weekly telephone contact with Maximus regarding contract components and input of screening into MMIS assuring timely completion of reviews.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. 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	Local Non-State 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	☒	☐	☒

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of enrolled case management providers that are carrying out operational and administrative functions according to policy and procedures. N: Number of case management providers that are carrying out administrative functions according to policy D: Total number of case management providers.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver participant's skilled nursing facility level of care determinations that were completed within 3 business days. N: Number of LOC determinations completed within 3 business days. D: Total number of LOC determinations.

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

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

Data Aggregation and Analysis:

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

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

The State Medicaid Agency will monitor to assure that the annual reassessment of the need for nursing facility level of care is completed within 3 days as is required in the contract. Any deficiencies will be tracked, and serious noncompliance issues will be addressed per the terms of the contract.

All Case Management providers will be required to submit an annual report to the State describing how they carry out the following delegated administrative functions: disseminate information concerning the waiver to potential enrollees, assist individuals in waiver enrollment. The information in the reports will then be evaluated by the State Medicaid agency to assure they are adequately administering these delegated functions and a summary report will be developed.

Record reviews will be conducted annually for 100% of waiver clients care plans and assessments to assure CM entities manage waiver enrollments against approved limits, adequately perform prior authorization of waiver services, and assure that waiver requirements are met. These reviews are conducted every year but the State Medicaid Agency alternates between onsite and offsite desk reviews every other year. Any errors will be documented and corrected.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

State Medicaid Agency staff are 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/ contract if necessary. The state maintains documentation that tracks training, policy changes, recouped funds and terminations.

ii. Remediation Data Aggregation

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☒	Technology Dependent	18		☒
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Individuals must be ventilator dependent for a minimum of 20 hours per day; medically stable, as documented by their primary care physician at a minimum on an annual basis, have identified an informal caregiver support system for contingency planning with the assistance of the case manager, be competent, as documented by the primary care physician at a minimum on an annual basis, to actively participate in the development and monitoring of the plan of care.

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)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

A comprehensive assessment will identify the formal and informal service needs of the individual and provider availability. If the plan of care could not assure the health, welfare, and safety of the individual, services would be denied. The individual would receive appropriate notification of appeal rights.

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

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

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

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

Per NDAC 75-03-23-09 (8) the Department of Human Services may grant approval to exceed the monthly service program maximum for a specific client if a client has a special or unique circumstance; and the need for additional service program funds does not exceed three months. Under emergency conditions, the Department may grant a onetime extension not to exceed an additional three months. The amount of additional services authorized would vary depending on the recipients needs and would require prior approval from the State Medicaid Agency.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

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

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).**

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

Once eligibility is determined, the applicant must choose an enrolled service provider(s). Entrance into the Waiver occurs, once all eligibility criteria have been met, and the service provider is authorized. The Department currently does not have a waiting list for the Technology Dependent Medicaid Waiver.

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **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:

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

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

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

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

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

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

  (*select one*):

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

    Specify:

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

    (*select one*):

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

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

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the state Plan**

    Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

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

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

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

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

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

◉ **The provision of waiver services at least monthly**

○ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

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

Specify the entity:

Maximus(formerly Ascend Management Innovations LLC)

- ○ **Other**

Specify:

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

Registered, Licensed Practical, or Licensed Vocational Nurse

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

The level of care instrument used by the State to evaluate and reevaluate whether an individual needs services through the waiver is entitled the Level of Care (LOC) Determination form. The completed document must be approved by Maximus formerly (Ascend Management Innovations, LLC.) to verify that the individual meets nursing facility level of care, as defined in North Dakota Administrative Code (N.D.A.C) 75-02-02-09. The LOC form assesses the client’s health care needs, cognitive abilities, functional status, and restorative potential.

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

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

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

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

evaluation process, describe the differences:

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

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

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

Case managers are responsible to retain a schedule of when re-evaluations are due. In addition, the contractor allows the State and the case manager to generate a report from their website that lists those individuals whose re-evaluations will become due the following quarter.

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

Case management entities retain copies of the instrument and approvals/denials of screenings. Maximus formerly (Ascend Management Innovations, LLC.) retains records that are available to the Department via their website. The website is available to the State Medicaid agency and allows us to electronically generate reports and documentation of screening and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who will have a completed level of care evaluation completed by the screening contractor. N: Number of waiver participants who had a LOC completed by the screening contractor. D: Total number of waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
A report generated from Ascend's website that lists completed screenings is verified against a State generated MMIS report that lists current waiver recipients.

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:

A report generated from the Maximus website that lists completed screenings will be verified against a list of waiver recipients		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 6 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Every 6 months

Performance Measure:
Number and percent of new waiver enrollees who had an initial LOC indicating need for Nursing Facility LOC prior to receipt of services. N: Number of new waiver enrollees who had a LOC prior to receiving services. D: Total number of new waiver enrollees.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:
A report generated from the Maximus website that lists completed screenings is verified against a State generated MMIS report that lists current waiver recipients.

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: A report generated from the Maximus website that lists completed screenings will be verified against a list of waiver recipients	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participant's level of care determinations that were re-evaluated at least annually for all enrolled participants. N: Number of waiver participants that were re-evaluated at least annually. D: Total number of waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
A report generated from the Maximus website that lists completed screenings is verified against a State generated MMIS report that lists current waiver recipients.

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 6 months	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Every 6 months

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

Performance Measures

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

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

Performance Measure:
Number and percent of level of care determinations that were submitted on the required form. N: Number of level of care determinations submitted on required form. D: Total number of level of care determinations.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial and annual level of care determinations made by a qualified reviewer. N: Number of level of care determinations made by a qualified reviewer. D: All level of care determinations.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
A report generated from the Maximus website that lists completed screenings is verified against a State generated MMIS report that lists current waiver recipients.

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

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

Data Aggregation and Analysis:

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

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

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

The State requires all screenings to be completed on a standardized tool. The State contracts with Maximus formerly (Ascend Management Innovations, LLC). to complete all LOC screenings. The contract requires that all LOC screenings be performed by a registered nurse or by licensed practical nurses, with at least three years of experience in behavioral health and three years of geriatric experience, receiving direct supervision from a registered nurse with a minimum of three years of psychiatric and three years of geriatric experience.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one on one technical assistance, group training, recoupment of funds, amending the contract or termination of contract for noncompliance if necessary. Documentation is maintained by the State that describes any remediation efforts.

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: Every 6 months

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).

HCBS Case Managers are required to explain waiver eligibility criteria to all potential waiver participants. This includes explaining that clients have a choice between receiving services in their home or in an institutional setting. Participants voluntarily choose to participate in the home and community-based program after discussion of all available options during their HCBS comprehensive assessment. This is documented by completion of Explanation of Client Choice, SFN 1597; This form must be completed before a person centered plan of care is submitted to the State Medicaid Agency.

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 case management entity maintains the forms. The State Medicaid Agency also maintains a copy of the Person Centered Plan of Care SFN 404.

Appendix B: Participant Access and Eligibility

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

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

When a consumer is unable to independently communicate with a case manager or State reviewer, a family member or community interpreter is present.

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

Appendix C: Participant Services

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

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case*

management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	**Case Management**		
Other Service	**Attendent Care**		
Other Service	**Non-Medical Transportation**		
Other Service	**Specialized Equipment and Supplies**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

An initial evaluation will be provided to an applicant to determine Waiver eligibility. Thereafter, at a minimum, four quarterly face to face contacts are required. However additional case management contacts may be provided as needed to implement, monitor or reassess an individual's care plan. Due to the complexity of the care provided to individuals who are technology dependent it is anticipated that frequent case management contacts will be required.

Participants 18-21 will receive this service if deemed medically necessary as EPSDT under the state plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Individual or Agency

Provider Qualifications

License *(specify):*

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

A person may not engage in the private practice of social work in North Dakota unless that person has been licensed by the board as a licensed independent clinical social worker (LICSW). Private practice of social work means the independent practice of social work by a qualified individual who is self-employed on a full-time or part-time basis and is responsible for that independent practice. LICSW means an individual who has a doctorate or master's degree in social work from a college or university and who has fulfilled the requirements for licensure or has been registered by the board for third-party reimbursement before August 1, 1997.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency

Frequency of Verification:

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

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:

Attendent Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

For consumers receiving Attendant Care Service, the cost is limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Department of Human Services. This cap may be increased as determined by legislative action. If the clients needs cannot be met within the allowed rate case management would explore other service options with the participant including nursing home placement. The case manager makes participants aware of the service cap.

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

To avoid duplicating services attendant care is not available to individuals 21 and over receiving personal care under the Medicaid State Plan. Medicaid State Plan Personal Care Service is not available to individuals 21 and over who are receiving attendant care service because all of the tasks that may be provided under the Medicaid State Plan Personal Care Service are also available under the attendant care service.

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

Participants 18-21 will receive this service if deemed medically necessary as EPSDT under the state plan.

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

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

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Attendent Care

Provider Category:

Individual

Provider Type:

Individual & Agency

Provider Qualifications

License *(specify):*

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

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

An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board of nursing; submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought; pass an examination approved by the board of nursing.

An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board; submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought; submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure; submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled Qualified Service Provider (QSP) 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Non-Medical Transportation enables individuals to access essential community resources or services in order to maintain themselves in their home and community.

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

Service tasks would not include transporting clients to/from work or school nor to facilitate socialization, to participate in recreational activities, or to medical appointments.

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
Individual	Individual or Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual or Agency

Provider Qualifications

License *(specify):*

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

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

Certificate *(specify):*

Other Standard *(specify):*

Individuals must have a valid driver’s license, road worthy vehicle, clear driving record, and proof of insurance. They must be an enrolled as a Qualified Service Provider (QSP) per N.D.A.C. 75-03-23-07. If a provider will be using another individual's vehicle to provide this service the owner of that vehicle must provide proof of insurance and a written statement that they have given the provider permission to use the vehicle for this purpose.

Agencies must be an enrolled QSP per N.D.A.C. 75-03-23-07. If an agency employee will be using another individual's vehicle to provide this service the owner of that vehicle must provide the proof of insurance and a written statement that they have given the provider permission to use the vehicle for this purpose

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's change of status

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Equipment and Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Specialized equipment, supplies, safety devices, or assistive technology that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These goods must not be attainable through other informal or formal resources. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture and design. Coverage may include the cost of set up, maintenance, and upkeep of equipment, and may also include the cost of training the participant or caregivers in the operation and/or maintenance of the equipment.

Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:
1) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
4) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
5) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

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

Limits

•The goods can only include the purchasing of items that relate directly to the clients care needs.
•Goods requiring structural changes to the home are not allowed through this service.
•This waiver service is only provided to individuals age 21 and over. All medically necessary “specialized equipment and supplies” for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.
•Pre-approval from the Department of Human Services is required before this service can be authorized.
•A written recommendation must be obtained by an appropriate professional (OT, PT, SLP, etc.) to ensure that the equipment will meet the needs of the participant prior to consideration for approval.
•Generic technical devices (tablets, computers, etc.) are not allowed.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled QSP 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's change of status

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.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

- (●) **No. Criminal history and/or background investigations are not required.**
- ( ) **Yes. Criminal history and/or background investigations are required.**

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

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

- ( ) **No. The state does not conduct abuse registry screening.**
- (●) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

For individual service providers the State Medicaid agency checks the - Board of nursing registry of licensed nurses and unlicensed assistive persons (UAP's) and Department of Health's Certified Nurse Assistant's and nurse aide registry; Attorney General's Sexual Offender's registry, ND State Court website, debarment database; excluded parties list system(EPLS), and the Department of Human Services HCBS provider complaint/termination database.

For agency service providers the State Medicaid agency checks the - debarment database; excluded parties list system (EPLS), and the Department of Human Services HCBS provider complaint/termination database. For newly enrolled service providers, the agency is responsible to assure direct service employees have met standards and requirements.

The State requires that a provider enrollment check list be completed and attached to each enrollment application. The checklist includes the date and initials of the State staff person who conducted the mandatory screening's. The checklist becomes part of the providers enrollment record.

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).**

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.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

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

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

Payments are not made to legal guardians. Payments are made to family members who are enrolled as Qualified Service Providers for the services that they are authorized to provide to the client. Relatives may be paid to provide attendant care and non medical transportation services only.

Payment is made according to policy and is limited to the services listed on the person centered plan of care and the authorization to provide service that is developed by the Case Manager. A copy of the authorization is given to the provider before they are eligible to provide the service. Some coding controls and edit checks are in place in the MMIS system to verify that the provider is authorized to provide the service before payment is made. Additionally, Qualified Service Providers are required to maintain records and are subject to the review/audit process.

○ **Other policy.**

Specify:

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

Any interested agency or individual may obtain a provider enrollment packet online on the Departments website. They can also request a copy, from either the Department or the Human Services Zone office. In addition, during community presentations, the State offers the opportunity for interested entities to receive enrollment packets. Consumers inform the State of interested parties and enrollment packet(s) are distributed. Advocacy organizations have encouraged interested entities to request enrollment packets and the Department responds to inquiries from potential providers and generates contacts to potential providers.

A realistic job preview DVD was created and is made available to individuals who may be interested in providing in home supports. Numerous educational sessions about being a direct service provider have been held statewide.

The State continues to revise the enrollment process to make it more consumer friendly.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of licensed waiver providers that initially met provider licensing requirements for the type of waiver service they provide. N: Number of waiver providers who initially met provider licensing requirements. D: Total number of new waiver providers who are required to maintain a license.

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

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

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: Upon initial enrollment

Performance Measure:
Number and percent of licensed waiver providers that maintained a valid license required to meet the provider qualifications for the type of waiver service they provide. N: Number of waiver providers who maintained a valid license. D: Total number of waiver providers who are required to maintain a license.

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

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (Whichever comes first)	

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: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (Whichever comes first)

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

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

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

Performance Measure:
 # and % of reviewed clients where the QSP a)provided services as required by plan b)arrived and left as scheduled c)client's appearance/ environment supported that the service was provided d)client's property was not taken or used e)client was treated respectfully f)client was not injured g)no rest. intervent./restraint was used. N:# of reviews where all assurances were met. D:# of client reviews.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

Performance Measure:
Number and percent of waiver providers who met Qualified Service Provider (QSP) Standards, per NDAC 75-03-23. N: Number of waiver providers who met standards. D: Total number of Qualified Service Providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid 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: Upon enrollment and re-enrollment every two years. State staff review all apps for compliance with all regulations. Providers who do not meet or no longer meet the requirements are denied.	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify: Upon enrollment and re-enrollment every two years

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

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

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

Performance Measure:
Number and percent of enrolled Qualified Service Providers (QSPs) that met the necessary provider training requirements for the type of waiver service they provide prior to furnishing waiver services. N: Number of waiver providers that met training requirements. D: Total number of Qualified Service Providers.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid 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: Upon enrollment, and re-enrollment every two years	

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: Upon enrollment, and re-enrollment every two years

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 licensed and non-licensed providers must enroll as Qualified Service Providers (QSPs) before they can be reimbursed for providing waiver services. All providers are required to complete provider enrollment applications and submit documentation of applicable licenses etc. upon enrollment and re-enrolment. For example, Nurse Managers must provide proof of a valid nursing license to the State Medicaid Agency before enrollment and reenrollment. The State maintains a database that lists the provider's enrollment date, expiration date, approved services etc. If a provider meets standards based on a license their enrollment date ends the same day as their license thus assuring they continually meet standards. Non licensed providers are enrolled for no more than two years. QSPs are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a QSP. Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment. The state has two staff who are responsible to monitor all aspects of provider enrollment including closures, denials and terminations. The State measures how many providers' meets standards by tracking enrollment rates, denials, and terminations.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions incuding restraint.

Case Managers will be required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

All licensed and non-licensed providers must enroll as Qualified Service Providers (QSPs) before they can be reimbursed for providing waiver services. All providers are required to complete provider enrollment applications and submit documentation of applicable training requirements/ licenses etc. upon enrollment and re-enrolment. For example, Nurse Managers must provide proof of a valid nursing license to the State Medicaid Agency before enrollment and reenrollment. Non- licensed providers must submit a valid documentation of competency signed by a health care professional or a CNA certification before they can provide waivered services.

The State maintains a database that lists the provider's enrollment date, expiration date, approved services etc. If a provider meets standards based on a license or certification their enrollment date ends the same day as their license thus assuring they continually meet standards. Non licensed providers are enrolled for no more than two years or the end date on their documentation of competency whichever comes first . QSPs are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a QSP. Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment. The state has two staff who are responsible to monitor all aspects of provider enrollment including closures, denials and terminations, training documentation etc. The State measures how many providers' meets standards and training requirements by tracking enrollment rates, denials, and terminations. State staff will not enroll a provider who does not meet the State's training requirements. In addition,when person centered plans of care are submitted, State staff check to make sure that the providers on the plan are enrolled and approved to provide the listed services. If the provider is not enrolled the care plan is denied and returned.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers will be required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance.

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: Upon initial enrollment and every two years thereafter

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.

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

Waiver services cannot exceed the amount equal to the highest monthly rate for the highest cost skilled nursing facility. This limit was determined to assure that services could be provided to individuals who require attendant care services. This amount may be adjusted upon legislative action.

Exceptions to the service limit will only be made per NDAC 75-03-23-09 for individuals already enrolled in the waiver whose circumstances change and require additional services to meet their health and safety needs. If the individual's needs cannot be met within the service limit the case manager will work with the client to explore other options including admittance to a skilled nursing facility or other program that can meet their needs. The case manager informs the participant of the service limits when developing the care plan at a minimum every 6 months. If waiver recipients needs exceed the service limit beyond the six month time frame per NDAC 75-03-23-09 they would be issued a written denial notice and would have the right to appeal.

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

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

Appendix 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 ND State Medicaid Agency has done a review and analysis of all settings where Technology Dependent waiver services are provided to eligible clients and the settings where waiver participants reside. The analysis included review of ND Century Code, ND Administrative Code, HCBS policy and regulations.

Through this process, the state has determined that the current settings where waiver services are provided and where waiver participants reside, fully comply with the regulatory requirements because the services listed below are individually provided in the recipients privately owned 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.

- Case Management
- Attendant Care /Nurse Management (component of attendant care)
- Specialized Equipment and Supplies

The following waiver services are not provided in the individual's private residence but based on our analysis also fully comply because it is an individualized service that allows the client to access the community to receive essential services from a provider of their choosing.

- Non-medical Transportation

North Dakota received its final systemic approval of its Statewide Transition Plan (STP) February 1, 2019. The State Medicaid agency will assure continued compliance with the HCBS settings rule by implementing and enforcing policy that will assure the continued integrity of the HCB characteristic that these services provide to waiver recipients. In addition, the State monitors all individual care plans, conducts case management reviews, client interviews/quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them.

Ongoing Monitoring:
The Department will ensure continued compliance with the HCBS settings rule in all of the States 1915 (c) Medicaid waivers by implementing and enforcing policy that will ensure the continued integrity of the HCB characteristics that these services provide to waiver recipients. The Department will review all future settings where waiver services will be provided and where waiver participants will reside to ensure that the settings meet the home and community-based settings requirement. The Department will assure continued compliance with all federal regulations. The Department will ensure that the experiences of individuals receiving HCBS in non-residential settings should be consistent with how those settings would be experienced by individuals who are not HCBS service recipients, such as access to food. Appropriate policies and procedures will reflect this requirement. The Department will use several practices at the recipient, provider, and state level to assure ongoing monitoring and compliance with all home and community-based setting requirements. The Department monitors all individual person-centered service plans, conducts quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them. The ongoing monitoring applies to all settings, including settings that are presumed to comply with the HCBS setting rule, and settings that are presumed to have institutional characteristics and are subject to the CMS heightened scrutiny review. The Department may make a presumption that privately owned or rented homes and apartments of people living alone or with family comply. The state will assure compliance through ongoing monitoring of the client's experience. This can be accomplished through ongoing consumer and family training and contact with case managers trained on the HCBS setting requirements. If there is a presumption that a privately-owned setting is institutional in nature, the case manager will be required to report that to the Department who will take steps to conduct a heightened scrutiny review to assure compliance.

At the recipient level, the State will monitor all individual person-centered service plans, conduct case management reviews, client interviews/quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them. Case Managers will monitor recipient experience and setting requirements at quarterly face-to-face visits.

The Department conducted statewide trainings with HCBS Case Managers in August & October 2014, December 2016, March & September 2017, and May, August, & September 2018, & May 2019 on the HCBS setting requirements and the person-centered service planning requirements. Training of Department staff, HCBS Case Managers, and the LTC Ombudsman has already been conducted and will continue annually. The HCBS settings criteria has been incorporated into the HCBS Case Manager training and into the initial training for the LTC Ombudsman. Department staff will utilize the CMS PowerPoint materials, FAQs, etc. that are available online to assist in the training.

Person-centered service plans have been updated and comply with the federal requirements as of July 2015. Setting requirements will be added to the provider standards for enrollment. State staff will conduct site visits of facilities upon initial enrollment and at renewal (every two years) to assure compliance. A summary of site visits results will be posted on Department's website. The

HCBS Case Managers will be responsible to assure ongoing compliance with all Medicaid recipients through monitoring done during their required quarterly visit to conduct the person-centered care plan meeting. Case Managers are also required to monitor during their quarterly face-to-face contacts to ensure an individual is being afforded the rights of privacy, dignity and respect, and freedom from coercion and restraint. Any violation of a waiver recipient's rights must be reported as complaint to the Department and/or Vulnerable Adult Protective Services. One of the quarterly visits must include a completion of a Medicaid Waiver Quality review, State Form Number 1154 (https://www.nd.gov/eforms/Doc/sfn01154.pdf) a copy of this review needs to be sent to the Department. Any issue identified in the client interview must be reported to the Department who will be responsible to work with the licensed provider to remediate any issues or violations related to the setting rule.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Plan of Care SFN 404

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

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

In order to provide culturally competent services, the State Medicaid agency enrolls Tribal Nations to provide both case management and direct waiver services to eligible Tribal members. The State Medicaid agency allows entities to provide both case management and direct waiver services only when no other willing and qualified providers are available to provide culturally competent services as a safeguard for potential clients who are eligible Tribal members where access to culturally competent qualified providers is an issue.

Safeguards to ensure that service plan development is conducted in the best interest of the participant include:

Individuals or their legal representative choose their own qualified service provider (QSP) from a list provided to them or may recruit an individual who is willing to seek the designation as a QSP. The QSP list is updated by State office staff on a monthly basis and includes the following information: provider name and contact information, provider type, provider number, provider approved service(s) and applicable rates, and provider (approved) global endorsements. Individuals use the information on the list to make an informed decision. Clients initial on the care plan that they choose their own provider. Clients are provided with information that they have the right to choose their own provider during the person centered planning process.

Once an individual or their legal representative selects a provider, they acknowledge on the care plan that they have also made an independent choice of services. The client signs a Client's Rights and Responsibilities form, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns directly to the State Medicaid agency. The form includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

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

The State Medicaid Agency requires a separation of who conducts the work. The person who provides case management cannot be the same person that provides direct waiver services to waiver recipients. All providers must keep service records that include the name of the person who provides the service including case management entities that also provide other HCB services. Annual Case management audits will include a record review that the same individual who provides case management is not also proving other HCB services. The annual audit also ensures the recipient has signed the Client's Rights and Responsibilities form. All person-centered plans of care are reviewed and approved by an HCBS Program Administrator.

Recipients are informed during the care plan meeting that if they have a dispute with the entity that provides their case management and direct services, they can contact the State directly to assist with a resolution. Recipients are provided with the State's toll free number and other contact information.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Clients can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Comments,questions and statements are addressed to the recipient. Recipients are allowed to respond in their own words and at their own pace. The recipient input is considered to be the most important; other team members act as advisors. Meetings focus on strengths, and goals of the recipient. Client's choose the service and provider and how much of the care plan to share with team members. If interpreters are needed they are provided.

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

Individuals are given a copy of the client rights & responsibilities brochure, it outlines client rights and responsibilities, and the case managers responsibilities. The individual care plan is developed with the client and or their legal representative, case manager and anyone else the client chooses to include in the process. Once developed, the client or their legal representative signs that they are in agreement with the plan of care. The plan is also signed by individuals or entities responsible for implementing the plan. A copy or certain portions of the plan are provided to those individuals as directed by the recipient and or their legal representative.

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):

When an individual applies for services the case manager initiates the person centered planning process by scheduling a meeting with the client and or their legal representative and any other individual that the client wants involved in the process. The meetings are conducted in the recipient's home at a time that is convenient to the recipient. Care plans are developed for a 6 month time period. However, the client can request meetings and revise the plan at any time. Clients who have communication issues are provided auxiliary aides or interpreters who speak their primary language to facilitate their full participation in the planning process. Cultural preferences are acknowledged and accommodations made when necessary.

The case manager conducts a comprehensive assessment. The comprehensive assessment includes the following elements: Cover sheet (assessment information, client identification, demographics, informal supports, legal representatives, emergency contacts, medical contact information, client stated goals, contingency plans (alternate provider), health-welfare -safety; Physical Health Information (nutrition, impairments, current health status, medication use, health risk factors); Cognitive / Emotional Status (cognitive behaviors, emotional wellbeing/ mental health); Functional Assessment (activities of daily living, instrumental activities of daily living, supervised / structured environment/ special needs); Home Environment(physical environment, adaptive equipment/environmental modifications); Services / Economic Assistance Information (services / funding sources). This process also includes an assessment of the person’s strengths and needs. Recipients are asked to describe their preferences, and goals are developed and documented in their own words including any desire for employment or alternative housing. Mechanisms for solving conflict and disagreement during the process are outlined during the meeting including discussing any conflict of interests.

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

All contacts relating to the client must be noted in the narrative section of the comprehensive assessment. Information that must be contained in the note includes the date, reason for contact, location of the visits, a description of the exchange if face to face between the case manager and the client or collateral contact, description of clients environment, appearance, and communication style, a list of identified needs, service delivery options, summary of the agreed upon care plan, client stated goals, progress, or change in goals, client satisfaction, a statement about the adequacy of the services and whether or not the provider is providing the service in the amount, duration, and frequency expected. A follow up plan addressing any issues must also be included in the narrative.

Participants are informed of home and community based services that are available in their communities (paid and unpaid) including services that are available under the waiver during the assessment process. On the individual care plan, the case manager lists other agencies and individuals who are providing services to waiver participants including informal supports. The individual care plan lists the type of service, providers name, units of service authorized, the providers rate and the total cost of care.

Participant goals and needs (including health care needs) are discussed during the assessment. Clients choose the type of service that will best meet their individual needs and choose who provides the care. All providers and services both paid and unpaid are listed. Client stated goals are documented on the individual care plan and reviewed at least every 6 months. The individual care plan reflects that the recipient chose the setting in which they reside and also includes a list of the person's strengths and positive attributes. The plan identifies potential risks and any approach that has been taken to mitigate those risks. Any deviation from helping the client to achieve their goals or assure their health and safety must be documented in the plan. The plan must include information on how safety needs were assessed based on the client’s abilities and current condition as well as other interventions and methods that were tried first but were not successful. The plan must include documentation of a timeline for a periodic review of these modifications to determine if they are still necessary to assure health and safety. Recipients must be fully informed of the plan and any modifications made to their stated preferences or goals to assure safety. Documentation must be included to assure that the intervention will not cause harm to the recipient.

The case manager monitors the plan quarterly or more frequently if necessary to assure services are being delivered in the amount, scope and frequency stated in the care plan, and that progress toward desired goals is being met. Other individual or entities that are responsible for carrying out portions of the care plan are listed. Anyone involved in carrying out the plan must receive a copy of the plan or a portion of the plan as determined by the recipient. The care plan is updated on an annual basis and is reviewed at six months. Case managers are required to conduct quarterly face to face visits with the recipient in the recipient's home at a time that is convenient for the recipient. Case management activities may occur more frequently if applicable. Clients can request a meeting to discuss or modify the plan at any time. Clients are made aware of their responsibility to participate fully in the care plan process and its implementation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Through the comprehensive needs assessment, potential risks are identified. 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, education, and housing. The case manager and client will review the assessment results and develop a care plan to diminish risk. The individual care plan lists potential risks and any approach that has been taken to mitigate those risks. Any deviation from helping the client to achieve their goals or assure their health and safety must be documented in the plan. Case managers must include information on how the safety needs were assessed based on the client's abilities and current condition as well as other interventions and methods that were tried first but were not successful. The plan must include documentation of a periodic review of these modifications to determine if they are still necessary to assure health and safety. Recipients must be fully informed of the plan and any modifications made to their preferences or goals to assure safety. Documentation must be included to assure that the intervention will not cause harm to the recipient.

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

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

For attendant care services, the nursing plan of care must identify what incidents should be reported and to whom. All reportable incidents must be reported immediately. Any incidents that results in client injury, or requires medical care, are reportable incidents. The nurse and attendance care provider are also responsible to report all incidents to the case manager. If the incident signifies any potential abuse, neglect, or exploitation, the Department must also be contacted immediately.

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

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipients home as scheduled; c) The environment and recipients appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other restrictive interventions. Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A Qualified Service Providers (QSP) list is maintained by State office staff and distributed to case management entities on a monthly basis. A searchable public database is also available on the Departments website to assist individuals in finding a QSP. This list includes information about all providers who are currently enrolled to provide services and who choose to have their information shared with the public. The information contained in the QSP list includes: provider name and contact information, provider type, provider number, provider approved service(s), applicable rates, and provider (approved) global endorsements.

This list is shared with the clients so they can choose a provider and is used by the case managers to assure that providers are eligible to provide the type of service being authorized. The individual checks and signs the care plan indicating they were afforded the opportunity to choose their service provider(s). When requested, Case Managers may assist recipients in contacting providers to check their availability. Case managers may also advocate for the clients by contacting community providers who are not currently enrolled as Qualified Service Providers to see if they would be willing to enroll and serve waivered recipients.

Case management entities are also informed of renewals, newly enrolled, and recently closed QSPs on a weekly basis thus assuring that clients have access to the most current list of providers available.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

All person centered plans are required to be forwarded to the State Medicaid agency. An HCBS Program Administrator receives and reviews the care plans. Issues relating to inconsistencies or incompleteness are returned to the case management entity or individual for resolution. A copy of person centered plan is available through an electronic file net system that is available to Medical Services Division/HCBS agency staff.

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

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

The goal is to review all case management entities each year, either through an on-site or desk review. In addition, all Technology Dependent waiver recipient assessments/care plans are reviewed via desk review by State Medicaid agency staff. These reviews are conducted annually.

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

D-2: Service Plan Implementation and Monitoring

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

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

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

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

The State monitors case management contacts. Each case management provider is required to document their billable case management tasks. Each case management provider is reviewed every year. A sample of the case managers files are reviewed and case management documentation is compared with billing history to assure compliance. If the case management documentation is not in compliance, case management fees are recouped.

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

The HCBS case manager reviews with the client or the clients representative the following information about qualified service providers (QSP's) who are available to provide the service and who have the endorsements required to serve the client:
- Provider name and contact information
- Provider type
- Provider number
- Provider approved service(s)
- Applicable rates

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

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

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

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

Service monitoring is an important aspect of care planning and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The case manager monitors the client's progress/condition and

the services provided to the client. As monitoring reveals new information to the case manager, regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case manager shall document all service monitoring activities and findings in the client's case file. When completing monitoring tasks, if the case manager suspects a QSP or other individual is abusing, neglecting, or exploiting a recipient of HCBS, an established protocol must be followed.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the Medicaid agency the case managers conducts recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration and frequency as required by the care plan; b) Arriving and leaving the recipient's home as scheduled; c) The environment and recipients appearance support that the service is provided in the amount outlined in the care plan; d)The services and amount of services meet the client's needs e)The available services meet the recipient's needs and assure that health, welfare and safety needs are met; e) The provider is not taking or using the recipient's property; f) The provider treats the recipient with respect; g) The provider has never injured the recipient; and h) The provider has never restrained or secluded the recipient or used other restrictive measures.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. The case manager reassesses the client, care plan, goals, and services on an ongoing basis, but must do a reassessment at six-month intervals and the comprehensive assessment annually. At the six-month and annual visit, the client stated goals must be reviewed and progress or continuation of the goals must be noted in the narrative of the comprehensive assessment.

b. Monitoring Safeguards. *Select one:*

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

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver recipients service plans that address all of the individual's goals. N: Number of service plans that address all of the individual's goals. D: Total number of service plans.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: All person centered plans are reviewed when they are received at the State Medicaid agency including initial ICPS, Modified ICPS and 6 month reassessments	

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**	☒ **Annually**

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

Performance Measure:
Number and percent of assessment/care plans that: a) are complete and include all required information. b) include all 4 required contacts documented in the narrative c) include a list of approved services, provider's name & rate, units, and total cost of care. N: Number of assessments/participant plans that meet a, b, c, and d. 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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:
Number and percent of the participant plans that are updated annually. N: Number of participant plans updated annually. 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of the participant plans are updated when changes are warranted. N: Number of participant plans updated when changes are warranted. D: Total number of plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

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:
Number and % of client reviews that determined services are being delivered by the type, scope, amount, duration and frequency specified in the care plan. N: Number of client reviews that determined services are being delivered by the type, scope, amount, duration and frequency specified in the care plan D: Total number of client reviews.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of HCBS comprehensive assessments that included confirmation that the clients have made a choice between waiver services and institutional care. N: Number of HCBS assessments that confirm client choice. D: Total number of comprehensive assessments.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 6 months	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Every 6 months

Performance Measure:
Number and percent of individual care plans that include confirmation that clients have made a choice between/among waiver services and providers. N: Number of individual care plans that confirm client choice. D: Total number of individual care plans.

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

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

	☒ **Other** Specify: All individual care plans are reviewed when they are received at the State Medicaid agency including initial ICPS, Modified ICPS and 6 month reassessments	

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 State will complete desk reviews of all Technology Dependent waiver recipients assessments / care plans during the first and third year of the waiver to determine if needs have been assessed according to policy and procedures. The State will also review 100% of the HCBS waiver files to determine if they have a current care plan.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipients home as scheduled; c) The environment and recipients appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipients needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipients property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers will be required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

State Medicaid office staff are responsible for addressing individual problems regarding care plans. Remediation techniques include but are not limited to providing one on one technical assistance, group training, adding information to the case management update that is emailed to all case managers, issuing corrective actions including the submission of missing or incomplete information, and recoupment of funds and or case management fees if necessary.

Problems identified during the quality review must either identify a remediation plan and/or must be reported to the State as a complaint. State Medicaid Agency staff are responsible for addressing all complaints. The State maintains a complaint database to track complaints by the date the complaint was received and responded to, and by type and resolution. 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)

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: HCBS Case Managers	☒ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Every 6 months

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

On the individual care plan the client must check both: I am in agreement with the services and selected the service providers listed above and I am in agreement with this plan. If either of these two acknowledgments are not checked and signed by the client or the clients legal representative the client or the legal representative must be given a completed termination, denial or reduction form to inform the client of their right to a fair hearing. The form includes contact information for the appeals supervisor. The care plan is signed and dated by the client or the legal representative at least every six months.

When an applicant/client is denied HCBS or if their services have been terminated or reduced, they are provided with the SFN 1647 HCBS Notice of Denial, Termination or Reduction form. If an applicant/client services are reduced, denied or terminated, they are informed of the timeline necessary to submit an appeal. Waiver recipients are also notified via the SFN 1647 that if a Medicaid appeal is received before the date of the termination is effective, services can continue until a hearing decision has been made. If the State Medicaid agencies decision is upheld, the client will be required to reimburse the State Medicaid agency for services provided after the termination date.

Copies of all SFN 1647 forms are kept in the clients file.

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.

If a client feels that there services will be adversely impacted by a decision that was made they can choose to request a conference with the Case Manager's supervisor or the Department of Human Services directly to discuss the issue. Clients are required to receive a copy of the client rights and responsibility brochure when they apply for services, it provides contact information for the Department of Human Services. The State's client appeal form also provides the name and phone number of the person they can contact to request a conference. The form further states that requesting a conference does not negate their right to receive a fair hearing.

The Department responds to all grievances but the most common reason recipients seek a conference is because they do not agree with: the outcome of their HCBS functional assessment, the amount or type of services they will receive; or the provider they want to work with cannot be enrolled because they do not meet all of the provider qualifications.

When an HCBS Administrator receives a complaint, staff will assess the situation and arrange a team consult if needed. All complaints must be address within 14 business days but most client requests are handled immediately. The State Medicaid agency uses a multi-disciplinary team approach if a complaint/grievance is received. At times, the team will be comprised of other HCBS team members, Medical Services Administration, Case Managers, Vulnerable Adult Protective Services, Health Department, Protection & Advocacy, Long Term Care Ombudsman and Aging Services Division. Others may be involved depending on the situation.

If the clients grievance is justified the Case Manager will be notified to take whatever action is necessary to correct the situation. If the grievance is found to be unsubstantiated the client always has the right to a formal hearing.

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:

State Medicaid Agency- Aging Services Division

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

The Department accepts any complaint received. When a participant notifies the State Medicaid agency of a grievance or complaint, the complaint is received, evaluated, applicable records relating to the complaint are reviewed, collateral information is obtained from the involved persons, and resolution is sought. If the complaint identifies immediate risk or harm to the client, law enforcement is involved as appropriate.

The Program Administrator who is responsible for complaints is a licensed social worker. When a complaint is received the Program Administrator asks questions as part of an intake process and uses that information as well as professional judgment to determine if there is imminent danger to the recipient. Law enforcement is contacted immediately if the Program Administrator believes that the recipient is in harm’s way or is being abused or neglected.

Other complaints are responded to based on severity or within 14 days. If the complaint is related to a denial / reduction / or termination of services, the client is informed that this process is not a pre-requisite or substitute for a fair hearing.

An access database is maintained of the complaints, type of complaint, and the resolution.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. 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 State of North Dakota has a mandatory reporting law for reporting suspected abuse or neglect of an adult. The law requires certain professions including qualified service providers, nurses, nursing home personnel, hospital personnel, occupational therapists, physical therapists, physicians, social workers and other to report abuse, neglect, and exploitation of vulnerable adults. Any other person may voluntarily report to the ND Department of Human Services or to law enforcement. A mandated reporter must report if in an official or professional capacity, he or she:
•Has knowledge that a vulnerable adult has been subjected to abuse or neglect; or
•Observes a vulnerable adult being subjected to conditions or circumstances that reasonable would result in abuse or neglect.
•Mandatory reporters are required to report as soon as possible.
•Any person required to report who willfully fails to do so is guilty of an infraction and subject to a fine of up to $1,000.

Reports are submitted using a standardized online submission system or a toll free central intake number. The Department of Human Services distributed information about the mandatory reporting law to all QSPs including those that provide care to waiver recipients and has done outreach and training to make people aware of this law.

The State Medicaid agency has written policies detailing the process of monitoring for abuse, neglect, or exploitation of all waiver participants. Policy states that the case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the State Medicaid agency. When case managers become aware of an incident, State law and policy requires that they gather specific information and report it to the appropriate party.

Incidents may include abuse, neglect, or exploitation. Abuse means the willful act or omission of a caregiver or any other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation to or of a vulnerable adult. Neglect means the failure of a caregiver to provide essential services necessary to maintain physical and mental health of a vulnerable adult; or the inability or lack of desire of the vulnerable adult to provide essential services necessary to maintain and safeguard the vulnerable adult’s own physical and mental health. Exploitation is the act or process of an individual using the income, assets, or person of a resident for monetary or personal benefit, profit, gain, or gratification.

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

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

Providers are subject to the mandatory reporting law and agree when they enroll to report potential abuse or exploitation when they become aware of the incident to the case manager.

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

Substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, arrest by law enforcement. If allegations are found to be unsubstantiated, the complaint is logged in the complaint database and no further action is taken.

The information is typically received via telephone or e-mail. However, information can also be obtained from letters,

face-to-face contact, the review process, or through general discovery.

The HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and uses observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipients home as scheduled; c) The environment and recipients appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipients property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other restrictive interventions.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. attendant care/ nurse management)providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
A) Result in imminent danger to the health, safety or security of the waiver recipient;
B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
C) Result in the hospitalization of the recipient;
D) Result in a sentinel event i.e. death of a waiver recipient

Providers must report the error within 5 days of the incident per policy.

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.

The clients, or their legal representatives, will receive a client's rights and responsibilities brochure describing their rights and their responsibility to self-report when they are approved for services. Case managers list their name and contact information for the case management entity on the brochure. Case Managers are required to have quarterly face to face contact with all waiver recipients. One of those visits is used to conduct an annual quality review where clients are asked specific questions about potential abuse, neglect, exploitation and have a conversation about the quality of their care. During all other contacts case managers are also required to discuss any issues the clients may be having with their care and address and follow up on all problems identified.

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

The Department of Human Services receives all mandatory reports of suspected abuse, neglect or exploitation of a vulnerable adult. If a mandatory report investigation determines that the vulnerable adult is a waiver recipient or if the allegation involves a qualified service provide the State Medicaid Agency is also notified. Case managers are also required to provide a report of abuse, neglect or exploitation to the State Medicaid agency if the vulnerable adult in the situation involves a recipient or qualified service provider. The HCBS staff person follows through by working with the case manager to assist with the investigation of the complaint or concern identified. Depending upon the incident, there are other entities that may be alerted about the allegations including the ND Board of Social Work Examiners and the ND Board of Nursing.

If the accused person is not a provider, the complaint is referred to the Vulnerable Adults Protective Services for resolution. If the accused is a provider the HCBS program staff person works with the case manager and determines a resolution. If the complaint presents an imminent risk, or potential criminal activity is suspected, law enforcement is immediately contacted by the case manager.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. attendant care and nurse management) are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency per policy. These conditions or practices must be abated or eliminated immediately. Providers must report the error within 5 days of the incident. The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

In addition, the nurse who provides the training for attendant care is required to maintain records related to:(1) the nursing activities that were taught to the attendant care provider and written instructions for the required tasks, (2) the re-evaluation of the client’s needs through an annual nursing assessment and any additional need for training of the attendant care provider (3) incidents that result in client injury or require medical care. The nurse must also provide written documentation to the State Medicaid agency that shows he or she has provided instructions to the attendant care provider that outlines the types of situations that are considered reportable incidents. Attendent care providers must also immediately report incidents that result in client injury or require medical care to the client’s primary care provider. If the HCBS case manager and State Medicaid agency staff determine that the incident is indicative of abuse, neglect, or exploitation, the appropriate protocol for abuse neglect resolution will be followed.

If a complaint involves a case manager, State Medicaid agency staff are responsible to investigate the incident and may involve the case manager's supervisor and other entities as appropriate.

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

The incident could result in continued monitoring, termination of providers, removal of client(s) from residences, arrest by law enforcement, or if allegations are not supported, it is considered unsubstantiated. When appropriate, either the case manager or the State Medicaid agency will inform interested parties including the client or responsible party of the resolution of the complaint.

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.

The Department of Human Services receives all mandatory reports of suspected abuse, neglect or exploitation of a vulnerable adult. If a mandatory report investigation determines that the vulnerable adult is a waiver recipient or if the allegation involves a qualified service provide the State Medicaid Agency is also notified. Case managers are also required to provide a report of abuse, neglect or exploitation to the State Medicaid agency if the vulnerable adult in the situation involves a recipient or qualified service provider. The HCBS staff person follows through by working with the case manager to assist with the investigation of the complaint or concern identified. Depending upon the incident, there are several entities that are alerted about the allegations. If the accused person is not a provider, the complaint is referred to the Vulnerable Adults Protective Services for resolution. If the accused is a provider the HCBS program staff person works with the case manager and determines a resolution. If the case involves an individual with Developmental Disabilities the DD Division and Protection and Advocacy are contacted for resolution. If the case involves Adult Family Foster Care (AFFC) clients the licensing agents responsible for AFFC licensing are contacted for resolution. If the case involves a client residing in a Basic Care or Assisted Living Facility the Long Term Care Ombudsman is contacted for resolution and depending on the concern, the North Dakota Department of Health or the Departments Agent responsible for Assisted Living Licensure may be involved. If the complaint presents an imminent risk, or potential criminal activity is suspected, law enforcement is immediately contacted by the case manager.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients i.e. all attendant care and nurse management providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency per policy. These conditions or practices must be abated or eliminated immediately. Providers must report the error within 5 days of the incident. The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

In addition, the nurse who provides the training for attendant care services is required to maintain records related to:(1) the nursing activities that were taught to the attendant care provider and written instructions for the required tasks, (2) the re-evaluation of the client’s needs through an annual nursing assessment and any additional need for training of the attendant care provider (3) incidents that result in client injury or require medical care. The nurse must also provide written documentation to the State Medicaid agency that shows he or she has provided instructions to the attendant provider that outlines the types of situations that are considered reportable incidents. Attendant providers must also immediately report incidents that result in client injury or require medical care to the client’s primary care provider. If the HCBS case manager and State Medicaid agency staff determine that the incident is indicative of abuse, neglect, or exploitation, the appropriate protocol for abuse neglect resolution will be followed.

If a complaint involves a case manager, State Medicaid agency staff are responsible to investigate the incident and may involve the case manager's supervisor and other entities as appropriate.

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

The incident could result in continued monitoring, termination of providers, removal of client(s) from residences, arrest by law enforcement, or if allegations are not supported, it is considered unsubstantiated. When appropriate, either the case manager or the State Medicaid agency will inform interested parties including the client or responsible party of the resolution of the complaint.

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 ND Department of Human Services monitors the use of restraints. The State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of restraints is part of the definition of abuse. Therefore, case managers are also responsible to report the use of restraints as a part of the monitoring process to assure health, welfare and safety. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

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

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

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

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restrictive interventions**

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

The ND Department of Human Services monitors the use of restrictive interventions. The State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of restrictive interventions is considered to be part of the definition of abuse. Therefore, case managers are also responsible to report the use of restrictive interventions as a part of the monitoring process to assure health, welfare and safety. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

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

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

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

restraints.)

◉ **The state does not permit or prohibits the use of seclusion**

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

The ND Department of Human Services monitors the use of seclusion. The State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of seclusion is considered to be part of the definition of abuse. Therefore, case managers are also responsible to report the use of seclusion as a part of the monitoring process to assure health, welfare and safety. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

○ **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.

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.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Number and % of waiver recipients/family/guardian that indicate during the annual quality review that the people paid to help them with their services treat them with respect,have never injured them,taken or used their property,or used restrictive interventions including seclusion and/or restraint. N: Number of waiver recipients that indicate all items were met D: Total number of waiver recipients

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and % of providers authorized to provide medication administration as part of a waivered service that submitted an assurance to the State Medicaid agency that they will report medication errors or omissions per policy. N: Number of providers that submitted required assurance. D: Total number of providers required to submit this assurance.

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

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

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Upon initial enrollment and reenrollment(every two years)	

Data Aggregation and Analysis:

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

Performance Measure:
Number and % of reported complaints that were addressed by State Medicaid staff within the required 14 day timeframe. N: Number of reported complaints addressed within 14 days D: Total number of complaints.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and % of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number of substantiated reports where follow up is completed. D: Total number of reports involving abuse, neglect or exploitation

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions***

(including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:
Number and % of waiver recipients family/guardian that indicate during the annual quality review that the people paid to help them with their services have never used restrictive interventions including seclusion and/or restraint. N: Number of recipients who indicate they have never been restrained. D: Total number of waiver recipients.

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of reported complaints regarding restraints that were substantiated through investigation, where follow-up is completed as required. N: Number of restraint complaints that are substantiated through investigation, where follow-up is completed as required. D: Total number of substantiated restraint complaints reported.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and % of annual nursing assessments that assure that the following overall health care standards are met: Personal care, repositioning, massaging extremities, ventilator care, tracheostomy care, nutrition, excursions/ outings, medications, and use of monitoring device. N: Number of assessments that meet all health care standards. D: Total number of assessments.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Nurse Manager listed on the clients person centered plan	☒ **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: Nurse Manager listed on the clients person centered plan	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of Technology Dependent Waiver recipients who did not require hospitalizations to treat tracheal infection. N: Number of waiver recipients who did not require hospitalizations for tracheal infections. D: Total number of waiver recipients.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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.

A “reported complaint” is any complaint or grievance that was reported to the Department of Human Service’s via phone, fax, email, in person contact or collateral contact. The Department accepts and reviews all complaints and must follow up on the complaint within 14 days of receiving it. Any State staff person can receive a complaint but there are two State staff designated to follow up on all complaints and make sure that the process is completed. These staff lead the process but a team approach is used to determine corrective actions etc. If the follow-up was not completed as required, the SMA would make a determination if the provider’s enrollment status will be affected.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including seclusion and/or restraint.

Case Managers will be required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. In addition, all waiver recipients are also given a participants rights brochure that is explained to them by the Case Manager. The brochure includes information on how to report a complaint.

All providers who administer medications i.e. attendant care and nurse education providers will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:
A) Result in imminent danger to the health, safety or security of the waiver recipient;
B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
C) Result in the hospitalization of the recipient;
D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately. Providers must report the error within 5 days of the incident per policy. The HCBS Case Manager must report hospitalizations to the State Medicaid Agency.

A licensed nurse, enrolled to provide nurse management is required to complete a nursing assessment when an recipient is enrolled in the waiver and annually thereafter to assess the clients overall health. The following health care standards are measured as they relate to the care that is being provided as part of the attendant care services: personal care, repositioning, massaging extremities, ventilator care, tracheostomy care, nutrition, excursions/outings, medications, and use of monitoring devise. This assessment must be forwarded and reviewed by a licensed nurse employed by the SMA. If the assessment shows that the care being provided is impacting the clients overall health the SMA is responsible to investigate the situation and will take remedial action to assure client health and safety including but not limited to provider termination.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Case Managers will be required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. If an immediate threat to the recipient is identified case managers will be required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy.

State Medicaid Agency staff are responsible for addressing all complaints. The State maintains a complaint database to track complaints by the date the complaint was received and responded to, and by type and resolution. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

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: HCBS Case Manager	☒ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Upon initial enrollment and reenrollment(every two years)

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §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; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

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

If the state's 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 3)

H-1: Systems Improvement

a. System Improvements

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

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

When pre-determined (QA) goals are not met or problems (that are not directly related to client care or health welfare and safety issues) are identified, the State discusses the issue(s) at team meetings and develops a plan of action. If the problem involves client care or health welfare and safety issues the problem is addressed immediately.

The action plan is documented in the team meeting minutes and may include, publishing the results of our quality improvement efforts in the HCBS Update that is provided to all Case Management entities, addressing unmet goals at the next Case Management training, rewriting updating policy/protocol as applicable.

Tools and/or instruments may also be revised to accommodate new measures. Annual letters are sent to all providers to provide them with information, make them aware of common errors and new requirements. If improper payment activities have occurred, adjustments to claims are processed, funds are recouped and providers may be placed on review or terminated if necessary. Provider training materials have been developed that include paper and web portal claims submission procedures, explanation of building codes and computer based modules on the way to correctly submit claims.

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: Continous & Ongoing

b. System Design Changes

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

System design changes are monitored by the HCBS team and discussed at HCBS team and administrative meetings. The State maintains a quality assurance plan that describes system improvements and other remediation efforts. The State 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.

The home and community base services (HCBS) team includes staff members from Aging Services Division responsible for administering Federal and State funded HCBS and the Medical Services Division – HCBS Administration unit, Money Follows the Person Program Administrator, the State Unit on Aging Director, and the Medical Services Director or Assistant Medical Services Director.

The core HCBS team consists of the Aging Services Director who has overall responsibility for the team, four HCBS Program Administrators, one Program Specialist and one office assistant. In addition, there are two staff (one HCBS Program Administrators and one enrollment specialist) located in the Medical Services Administration Unit who have responsibility as it relates to the QSP enrollment process, system changes related to provider billing, rate setting and provider audits.

One of the Aging Services Human Service Program Administrator's who is a licensed Registered Nurse is responsible for administering all aspects of the Technology Dependent Medicaid waiver this includes quality assurance and system improvement. The program specialist and office assistant provide additional support. The other three Human Service Program Administrators positions are responsible for other HCBS administrative duties including but not limited to staff supervision, oversight of case management, conducting case management reviews, and complaint resolution.

Aging Services has partnerships with other units within the Medical Services Division including staff who are responsible rate setting, fiscal administration, utilization and review, home health, and SURS. External resources are vital to the development of effective and efficient services. These entities participate as applicable: County Social Service Boards, service providers, family members, consumers, Long Term Care Association, advocates, and other interested parties.

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

The States quality improvement strategy is discussed during team meetings and administrative meetings that are scheduled monthly. System changes and common errors or individual problems that have been identified via the audit process are also discussed. Once a year the State calculates statistics and reviews the results of the quality improvement plan. Trends are tracked and reviewed against the previous years results to see where improvements have been made and where future quality improvement efforts need to be focused. The results of this analysis are discussed with the HCBS team and the adult services committee and distributed to Case Managers through the quarterly update or annual training. Issues regarding recipient health and welfare are addressed immediately.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

We utilize internal tools that include quality of life information that are completed annually and as part of on-site case management audits.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

The Department of Human Services currently has approximately 1200 enrolled Qualified Service Providers (QSPs) including case management entities. Waiver providers are not required to secure and independent audit of their financial statements. Waiver providers are not required to secure an independent audit of their financial statements and not all providers are subject to a single State audit.

The State Medicaid agency completes onsite or desk reviews of all enrolled case management providers on an annual basis to determine if operational and administrative functions have been carried out according to policy and procedures. Case Management audits alternate each year between desk audits and onsite audits. In addition, the State Medicaid agency completes desk reviews of all Technology Dependent waiver recipients paid claims data to determine if activities and tasks were billed/paid within allowable limits. The paid claims data review is conducted annually.

The State Medicaid agency also completes a minimum of 5% or 85 QSP reviews annually. The 85 entities may provide services under all HCBS programs in ND including the two State funded programs, the HCBS and Technology Dependent waiver and Medicaid State Plan - Personal Care. The process to choose who will be reviewed from this group is not random. The providers are chosen because irregularities in their billing patterns or other concerns have been identified. The State Medicaid agencies provider review process consists of one year of claim history and the evaluation of a minimum of one month of HCBS case management records/activities, and provider records. Within these reviews, various components are evaluated to determine if activities and tasks were billed/paid within allowable limits. Provider records and logs are evaluated to determine if proper procedure codes were utilized, and services were delivered in accordance with the authorization of services.

In addition, the State Medicaid Agency performs audits of certain services that have been identified through discussion with HCBS and SURS team members to have a higher potential for inappropriate billing or other irregularities that would warrant a review of all claims data related to that service. Annually or as needed, the Medical Services Division HCBS unit and staff from the Aging Services Division determine audit topics relative to the services provided by the Aging Services Division. The Fraud, Waste, and Abuse (FWA) Administrator serves as an advisor on the auditing activities to ensure consistency and integrity throughout the process. Factors that lead to a decision to audit a particular service include looking at services with high utilization, frequent errors, and or patterns of irregular billing. A minimum of one targeted service audit is conducted annually.

Different waiver services are generally audited each year but a service that has already been audited may include another audit within that year to assure compliance or technical assistance efforts were achieved. Sample size for service audits is based on a 95% confidence level and a confidence interval of 5 based on the number of clients utilizing the service during the timeframe of the data pull. There may be instances where the sample size is such that every provider in the state would not necessarily be selected randomly for an audit. In those instances, five claims for each provider are randomly selected to ensure that each provider has at least one claim included in the audit. Then, the amount of claims needed to meet the sample size is randomly selected from the remaining claims in the data report. The link used to establish the sample size is: http://www.raosoft.com/samplesize.html

Corrective action plans are required if errors are found. The reviewer is responsible to follow up with all corrective actions to assure compliance before the review can be closed. Corrective action plans may include a requirement that a provider with a history of billing errors will audited again in the near future to assure compliance.

The following waiver services will be prior authorized in the MMIS system and will require a Service Authorization (SA) to be entered for all clients. Attendant care, Non-Medical Transportation, Specialized Equipment and Supplies. If there is not a valid SA in the system, claims will be denied. In addition, if a provider tries to bill over the authorized amount or for a service that is not authorized the claims will be denied.

The State agency responsible for conducting the states financial audit is the Office of the State Auditor. An audit of the State of North Dakota Comprehensive Annual Financial Report is conducted annually by the State Auditors Office. This audit involves examining, on a test basis, evidence supporting the revenues, expenditures and disclosures in the financial statements, assessing the accounting principles used and evaluating the overall financial statement presentation.

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

The State Auditors Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single

Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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:
Number and percent of desk reviews of all technology dependent waiver provider's paid claims data that determined if activities and tasks were billed/paid within allowable limits. N: Number of reviews that determined activities and tasks were billed/paid within allowable limits. D: Total number of reviews.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of desk reviews of all technology dependent waiver provider's paid claims data that determined services were paid at the correct rate. N: Number of reviews that determined services were paid at correct rate. D: Total number of reviews.

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

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

Data Aggregation and Analysis:

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

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

Because of the low number of recipients being served under this waiver the State conducts a review of 100% of the paid claims data to assure claims are being paid correctly. The term technology dependent waiver providers includes all claims data for every service provided in this waiver. Waiver providers are also subject to a review of their documentation to assure that services are rendered and match their billing. In addition, the waiver recipients are asked if the services are being provided as required and the case manager and the nurse manager conduct a minimum of 4 face to face visits per year to assure care is being provided.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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 State Medicaid Agency is responsible for addressing individual problems. Resolution methods include but are not limited to recoupment of funds, providing education /technical assistance, rewriting billing instructions, sending written corrective action plans, conducting pre and post payment reviews on 100% of paid claims data, placing providers on review, and terminating provider status if necessary.

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***	☒ ***Annually***

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

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

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

Rates are reviewed biannually when the Department's budget is prepared. The sufficiency of a rate is determined based on the number of clients who are able to access services, including access in rural areas, the number of providers enrolled to provide care & public comment. The SMA sets rates for services after the Legislature (LEG) appropriates funds for those services. Rates may be increased by LEG action. The LEG may or may not grant an inflationary increase during the LEG session which is biennially. Testimony is encouraged during LEG Budget Hearings & Interim Human Serv. Committee hearings, qualified service providers (QSPs) give testimony regarding QSP rates.

In 2020 rates for all waiver services were reviewed in preparation for EVV and FLSA implementation. NMT rates are being updated for EVVS to ensure compliance with FLSA In-home final rule.

The SMA gathers input on HCBS including rates via a survey process or public hearings that are held in every region of the State, including reservation communities. The public input is compiled & considered when determining budget & service delivery priorities. Waiver recipients are made aware of the QPS's rate when they choose their QSP. The rate for each service is also listed on the client's person centered plan. When LEG rate increases are approved, clients who have a recipient liability are informed in writing that the service costs will increase.

The SMA maintains a QSP list https://secure.apps.nd.gov/dhs/qsp/qspsearch.aspx that includes the rates by provider. This list is available to clients & the public via online database.

Rates for Medicaid waiver services are adequate to recruit and retain qualified providers across the State to sufficiently meet client needs. We do not have a waiting list for waivered services. Rates cannot be adjusted retrospectively.

A 3% inflationary increase for all services was applied to the WY1 rate for WY2-WY5. The amount was based on the agencies experience with historic inflationary increase amounts. The States establishes rates by maintaining an established fee for service schedule.

The State does not incorporate difficulty of care factors into the rates and the rates do not include any geographic adjustment factors. Rates have been determined to ensure that payments across the State are equivalent.

Attendant Care:
The caps on attendant care rates are based on the State's current fee for service rate for similar services and were initially established after considering the following information: minimum wage inflated by 30% to cover administrative costs, the mean wage that was being paid to individuals who were currently providing waiver services and Job Service information about the average salary paid in North Dakota for similar work. The blended rate was calculated by using the current agency and individual fee for service rate divided by two.

When an independent, self-employed service provider or agency enrolls as a QSP for attendant care, the individual or agency provides an initial request for a rate. If the rate is within pre-determined limits established by the State, the provider is issued the rate requested.

The cap for agency attendant care rates is higher because they include allowable admin costs to the agency. Allowable admin costs include the indirect cost of providing services such as telephone, billing, recruitment costs and office space.

Attendant care can be provided up to 24 hours per day even while the client is receiving non-medical transportation because the nature of the care may require that an attendant travel with the recipient to assure their care needs are met.

Nurse Management: (Component of Attendant Care)
Agency providers of the nurse management portion of attendant care are required to forward agency cost reports at the time of enrollment. Direct, indirect, and admin costs are provided to the State. The agency cost reports are reviewed for reasonableness and a provider rate is set. Reasonableness is determined by evaluating whether reported costs are client related and necessary to the provision of the service. Admin costs in excess of 15% of the direct care costs for these services are excluded when calculating the rate.
When an individual, self-employed service provider enrolls as a QSP for nurse management, the individual provides an initial request for a rate. If the rate is within the pre-determined limit, the provider is issued the rate requested. If the rate is greater than the rate is reduced.

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

admin costs to the agency. Allowable admin costs include the indirect cost of providing services such as telephone, billing, recruitment costs and office space.

The nurse management rate was originally set after considering Job Service data about the average wage paid in ND for RN's and LPN's inflated to cover administrative and other costs.

The cap for agency rates is higher because they are based on actual costs and include allowable administrative costs to the agency. Allowable administrative costs include the indirect cost of providing services such as telephone, billing, recruitment costs and office space. Currently administrative costs in excess of 15% of the direct care costs for providing services are excluded when calculating the rate.

Case Management:
Case management rates were based on the rates that are used to pay for case management services in the HCBS waiver. Case Management rates were initially established by a committee and were based on the average salary being paid to social workers at that time and other information provided by the case management entities. That rate was then inflated to account for the estimated average additional time it takes to participate in ICP meetings with a team and/or conduct additional home visits.

The unit rate is a monthly rate. The estimated number of units is 12 units per consumer, per year. If case manager has client contact that impacts eligibility, care planning, etc. or they complete an assessment with the client on a given day during the month, they would be paid 1 unit of case management at the monthly rate. The max amount they could receive would be the monthly rate regardless of how many billable tasks they performed that month. Consumers are made award of the CM costs on their ICP. Each case management agency receives the same rate for providing case management services.

Rates for self-employed independent contractors who enroll to provide case management services under the waiver were calculated by using the US Bureau of Labor and Statistics average wage paid for social workers in ND plus the average cost of benefits. That rate was then multiplied by the average amount of time it takes to complete an annual assessment and the average time it takes to complete a quarterly contact.

Non-Medical Transportation:
The NMT rate is being updated to create a unit rate. The unit rate was based on the cost of current services in the HCBS (aged & disabled) waiver for an average 1 hour trip.

Specialized Equipment:
Specialized equipment costs are based on the actual cost of the equipment. Cost proposals for specialized equipment, are reviewed to assure that preliminary costs do not exceed the individual budget amount.

In all cases, the provider is notified of the initial rate and is notified when the rate changes.

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:*

Specialized equipment and supply vendors will submit payment using the professional claim MMIS portal. Claims submitted via the web portal go directly from the provider to MMIS.
The state has chosen Therap LLC as the states EVV provider. The estimated go live date is 1-1-2021. The following waiver services are subject to EVV: attendant care, (including nurse management).

Individual QSPs will also use EVV for non-medical transportation to track time worked as it relates to FLSA in home care rule.

All individual and agency QSPs who provide services subject to EVV will have access to the Therap EVV system and the corresponding billing module free of charge. The Therap system uses EVV and other provider data to generate a professional claim via a billing module that can be submitted by the provider directly to MMIS. MMIS validates the professional claims data against all required edits and adjudicates the claim. Payments are sent directly to providers from MMIS.

ND has chosen an open EVV model that will also allow providers of the impacted services to choose to use their own EVV system and submit data to an aggregator vendor contracted by the state. Individual and agency QSPs who have their own EVVS will submit a professional claim directly to MMIS via the web portal. MMIS validates the professional claims data against all required edits and adjudicates the claim. Payments are sent directly to providers from MMIS.

All service plans are reviewed and approved by Aging Services staff. The information from the service plan is used to create an authorization to provide services that is given to the provider before services begin. It lists the type, amount, duration, and frequency of the services the provider is authorized to provider to the participant. In addition, the information from the approved plan is used to create a service authorization (SA) in MMIS for all waiver services. The SA includes the type, amount, and duration of the services authorized. When claims are submitted the claims, data is checked against the SA for accuracy. If the claims are billed within the authorized limits it pays, if not, it denies. No SA is created for adult residential service and family personal care because MMIS contains other edits that prevent billing errors for these services.

Providers of impacted EVV services that choose to use Therap as their EVV system will receive a service authorization generated in the Therap system. Therap will share the SA with MMIS via a valid transaction for adjudication and validation of the claims information against the SA.

Case Managers have frequent contact with waiver recipients and are required to make a minimum of four quarterly face to face visits each year. The visits include an assessment to determine if their service needs are being met. One of the quarterly visits is a quality review where the recipient is asked questions about the frequency and quality of their care to assure services are being rendered in the type, scope, amount, and frequency listed on the care plan. In addition, staff from Medical Services conduct provider reviews which include a review of billing records and provider documentation to assure services were rendered per the authorization to provide services.

If billing errors are found providers are notified of the issue in writing and adjustments are filed which create an accounts receivable in MMIS to recoup the funds. If a provider is closed or is not actively billing, they are asked to remit the payment ASAP. If they do not respond within the timeframe requested the matter is turned over to a collection agency.

All adjustments and corrections are reported on the CMS 64 report which reduces the State's federal reimbursement.

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:*

ND Health Enterprise MMIS will deny claims if the individual is not an approved Medicaid recipient. The State receives reports from Maximus formerly (Ascend Management Innovations, LLC) identifying individuals who have been screened eligible for the waiver and the information, including the eligibility period of the screening, is entered into a functional eligibility system (FES). The FES system interfaces with the States' MMIS system to enroll the recipient in the appropriate waiver benefit plan. If a recipient is not enrolled in the waiver benefit plan the claim will not pay.

All services with the exception of case management, will be prior authorized in the MMIS system and will require a Service Authorization (SA) to be entered for all clients. If there is not a valid SA in the system, claims will be denied. In addition, if a provider tries to bill over the authorized amount or for a service that is not authorized the claims will be denied.

To assure proper claims payment, the Department also conducts post payment audits to evaluate payments for accuracy, accountability and reasonableness. As part of the State's quality assurance efforts desk reviews of Technology Dependent waiver recipients paid claims data is reviewed annually to determine if errors exist. All technology dependent waiver providers are subject to audits that include a review of the provider's documentation to determine if the services were provided and match the providers billing. In addition, during the annual quality review waiver recipients are asked if the services are being provided as scheduled. If the consumers states that the services are not being provided the State is responsible to follow the complaint protocol to resolve the situation and implement corrective actions.

If any of these reviews reveal payments that are in excess of what is authorized or are unallowable they are recouped by the State. Recoupments are made through a provider adjustment or direct provider payment.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

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

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

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

Appendix I: Financial Accountability

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

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

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

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

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

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

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Human Service Zones and North Dakota Indian Tribal entity may choose to enroll to provide services for which they are qualified to provide.

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) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- (●) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ( ) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §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.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

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

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

Appendix I: Financial Accountability

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

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

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

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

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

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

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

Appendix I: Financial Accountability

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

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

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

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

Appendix I: Financial Accountability

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

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

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

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

Do not complete this item.

Appendix I: Financial Accountability

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

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

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

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

Appendix I: Financial Accountability

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

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

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

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

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	223522.49	23301.68	246824.17	270465.00	23320.92	293785.92	46961.75
2	230363.67	23954.12	254317.79	283988.25	24020.54	308008.79	53691.00
3	237227.19	24624.84	261852.03	298187.66	24741.16	322928.82	61076.79
4	244756.65	25314.33	270070.98	313097.04	25483.40	338580.44	68509.46
5	251998.23	26023.14	278021.37	328751.89	26247.90	354999.79	76978.42

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	3	3
Year 2	3	3
Year 3	3	3
Year 4	3	3
Year 5	3	3

Appendix J: Cost Neutrality Demonstration

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

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

The average length of stay was calculated by estimating the number of days that waiver services would likely be used based on the needs of individuals who are technology dependent, medically stable, with long-term continual needs on a 24-hour basis. The average length of stay is 335 days. Our estimate is based on the assumption that there will be approximately 30 days in which waiver services are not provided due to acute hospital stays, individuals going on and off the waiver etc. The number of days is based on the State experience with other waiver populations.

The State believes that the current case management providers would have the capacity to accommodate up to 3 participants while maintain cost neutrality.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimated number of service users is 3. All estimates below (except specialized equipment and non-medical transportation) are based on the #0468 Technology Dependent waiver capacities which have been adequate to meet the requested need for these services.

The estimated number of waiver recipients who will choose an independent case manager is 1.

The estimated number of waiver recipient who will use specialized equipment and supplies is 2.

The estimate of the number of units for case management provided by an agency or independent case manager is 12 units per consumer. This number is based on the complexity of the services being provided and the need for continual monitoring of the care plan.

The cost per unit for agency case management was calculated by taking the current agency rate for completing one case management assessment per year plus the current agency rate for 11 subsequent contacts divided by the number of units.

The cost per unit for independent case management was calculated by taking the current independent case management rate for completing one case management assessment per year plus the current individual case management rate for 11 subsequent contacts divided by the number of units.

The estimate of the number of units for attendant care is 32,160 units. Units per user is based on the need for 24-hour care for the estimated length of stay. The cost per unit is based on the current average Qualified Service Provider Rate for agencies and individuals.

The estimate of the number of units for nurse management, which is a component of attendant care, is 800 units. Units per user were based on an estimate of the number of hours needed to provide nurse assessments, care planning, delegation, and monitoring quality of care. The cost per unit is an average rate based on the current highest rate allowed for agency and individuals enrolled to provide the nurse management component of attendant care.

The estimated number of units for non-medical transportation is based on 1 trip per week or 52 trips per year. Non-medical transportation costs per unit are based on the cost of providing similar services in the HCBS (aged & disabled) waiver and assume an average 1 hour trip. Due to lack of data in the #0468 technology dependent waiver the number of units per year was based on average use from the HCBS waiver that serves the aged and disabled.

The estimated number of units for specialized equipment and supplies is 1. The specialized equipment and supplies cost per unit was calculated using the current average per item cost of specialized and equipment usage in the HCBS Medicaid Waiver which serves elderly and disabled individuals.

No inflationary increase was included in WY1. A 3% inflation factor based on historical inflation was added for 7 months of WY2 and for WY 3-5 for all services. The 3% increase applies to all costs per unit for the agency and independent case managers. 3% was used in subsequent years because that is that average inflationary increase that has been approved by the Legislature.

No utilization increase was made for attendant care because it is a 24-hour service. No growth was added for case management, non-medical transportation or specialized equipment and supplies.

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:*

Due to the low census of this waiver the most recently approved 2018 372 report for the HCBS waiver was used to calculate Factor D'. It indicates that the estimated cost of all other services paid on behalf of waiver recipients averaged $22667. This does not include cost of prescribed drugs that are furnished to Medicare/ Medicaid eligible individuals under Part D. For WY1-WY5 this figure was inflated by 2.8% based on the current medical Consumer Price Index (CPI).

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these*

estimates is as follows:

The G factor is based on the current highest rate in the highest cost nursing facility in North Dakota for individuals with an ES3 classification. The highest nursing home rate was used because this is the classification that would be used to establish a rate for an individual who is ventilator dependent.

The amount was inflated by 5% for WY 2-5. The 5% inflationary increase is based on historical increases applied to nursing home services. The 5% historical inflationary factor is based on the agencies experience.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Medical Assistance spend-down report for Mar 2020 was used to calculate the average cost of other services for individuals residing in nursing facilities. Other services include other Medicaid services that are available to a nursing home recipient but not otherwise provided for in the nursing home rate i.e. hospital stays etc. The average cost per person per year is $7453.60. This figure was inflated by 2.5% to account for a 2020 actual legislative increase. The average annual cost of other services per year for three recipients is $22919.82. This figure does not include the cost of prescribed drugs furnished to dual eligible under Medicare Part D.

The amount was inflated by 3% for the last 7 months of WY 2 and for all of WY3- WY5. The 3% inflationary increase is based on historical inflation for WY 3-5. Historical inflation is based on the agencies experience.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Attendent Care	
Non-Medical Transportation	
Specialized Equipment and Supplies	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4931.40
			GRAND TOTAL:			670567.48
			Total Estimated Unduplicated Participants:			3
			Factor D (Divide total by number of participants):			223522.49
			Average Length of Stay on the Waiver:			335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Case Management	1 X per month	1	12.00	112.85	1354.20	
Case Management	1 x per month	2	12.00	149.05	3577.20	
Attendent Care Total:						644745.60
Attendant Care	15 min.	3	32160.00	6.32	609753.60	
Nurse Management	15 min.	3	800.00	14.58	34992.00	
Non-Medical Transportation Total:						2040.48
Non-Medical Transportation	Per Trip	3	208.00	3.27	2040.48	
Specialized Equipment and Supplies Total:						18850.00
Specialized Equipment and Supplies	Per Item	2	1.00	9425.00	18850.00	
				GRAND TOTAL:		670567.48
				Total Estimated Unduplicated Participants:		3
				Factor D (Divide total by number of participants):		223522.49
				Average Length of Stay on the Waiver:		335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						5079.36
Individual Case Management	1 X per month	1	12.00	116.24	1394.88	
Case Management	1 x per month	2	12.00	153.52	3684.48	
Attendent Care Total:						664493.28
Attendant Care	15 min.	3	32160.00	6.51	628084.80	
Nurse Management	15 min.	3	808.00	15.02	36408.48	
				GRAND TOTAL:		691091.02
				Total Estimated Unduplicated Participants:		3
				Factor D (Divide total by number of participants):		230363.67
				Average Length of Stay on the Waiver:		335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation Total:						**2102.88**
Non-Medical Transportation	Trip	3	208.00	3.37	**2102.88**	
Specialized Equipment and Supplies Total:						**19415.50**
Specialized Equipment and Supplies	Per Item	2	1.00	9707.75	**19415.50**	
				GRAND TOTAL:		**691091.02**
				Total Estimated Unduplicated Participants:		**3**
				Factor D (Divide total by number of participants):		**230363.67**
				Average Length of Stay on the Waiver:		335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5231.76**
Individual Case Management	1 X per month	1	12.00	119.72	**1436.64**	
Case Management	1 x per month	2	12.00	158.13	**3795.12**	
Attendent Care Total:						**684286.56**
Attendant Care	15 min.	3	32160.00	6.70	**646416.00**	
Nurse Management	15 min.	3	816.00	15.47	**37870.56**	
Non-Medical Transportation Total:						**2165.28**
Non-Medical Transportation	Trip	3	208.00	3.47	**2165.28**	
Specialized Equipment and Supplies Total:						**19997.96**
Specialized Equipment and Supplies	Per Item	2	1.00	9998.98	**19997.96**	
				GRAND TOTAL:		**711681.56**
				Total Estimated Unduplicated Participants:		**3**
				Factor D (Divide total by number of participants):		**237227.19**
				Average Length of Stay on the Waiver:		335

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
Case Management Total:						5388.60
Individual Case Management	1 X per month	1	12.00	123.31	1479.72	
Case Management	1 x per month	2	12.00	162.87	3908.88	
Attendent Care Total:						706055.76
Attendant Care	15 min.	3	32160.00	6.91	666676.80	
Nurse Management	15 min.	3	824.00	15.93	39378.96	
Non-Medical Transportation Total:						2227.68
Non-Medical Transportation	Trip	3	208.00	3.57	2227.68	
Specialized Equipment and Supplies Total:						20597.90
Specialized Equipment and Supplies	Per Item	2	1.00	10298.95	20597.90	
				GRAND TOTAL:		734269.94
				Total Estimated Unduplicated Participants:		3
				Factor D (Divide total by number of participants):		244756.65
				Average Length of Stay on the Waiver:		335

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
Case Management Total:						**5550.36**
Individual Case Management	1 X per month	1	12.00	127.01	**1524.12**	
Case Management	1 x per month	2	12.00	167.76	**4026.24**	
Attendent Care Total:						**726932.16**
Attendant Care	15 min.	3	32160.00	7.11	**685972.80**	
Nurse Management	15 min.	3	832.00	16.41	**40959.36**	
Non-Medical Transportation Total:						**2296.32**
Non-Medical Transportation	Trip	3	208.00	3.68	**2296.32**	
Specialized Equipment and Supplies Total:						**21215.84**
Specialized Equipment and Supplies	Per Item	2	1.00	10607.92	**21215.84**	

GRAND TOTAL:	**755994.68**
Total Estimated Unduplicated Participants:	**3**
Factor D (Divide total by number of participants):	**251998.23**
Average Length of Stay on the Waiver:	335