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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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*):
Autiam Spectrum Disorder (ASD) Birth through Four

C. Type of Request: new

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**

☐ **New to replace waiver**
Replacing Waiver Number:

☐ **Migration Waiver** - this is an existing approved waiver
Provide the information about the original waiver being migrated
Base Waiver Number:
Amendment Number (if applicable):
Effective Date: *(mm/dd/yy)*

Waiver Number: ND.0842.R00.00
Draft ID: ND.12.00.00

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

E.
Proposed Effective Date: *(mm/dd/yy)*
11/01/10
Approved Effective Date: 11/01/10

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

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
The State additionally limits the waiver to individuals, birth through four with a diagnosis of Pervasive Developmental Disorder (PDD)a diagnosis on the autism spectrum (ASD)as determined within the DSM-revision IV. Based on established procurement protocol a request for proposal will be published to identify eligibility team members. The team will consist of professionals with advanced training in Autism Spectrum Disorder issues related to children birth through four. The team will determine or confirm diagnosis of PPD based on multidisciplinary evaluations. Quarterly, an assigned eligibility team member will review data to determine if the child is making progress or if the local team needs to define the implementation strategies.

Acumen responded to the initial Request for Proposal for a Fiscal Agent and received a 12 month contract with option of renewal for 5 additional years. A Request for Proposals will be issued for fiscal agent services prior to the end of the current contract which ends 3/31/11

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.

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

The objectives include:

1. The state wide eligibility assessment team will validate the child's diagnosis for placement on the waiver and provide recommendations to a local team that includes the family.
2. Intense coordination and implementation of the Person Centered Service Plan (PCSP),
3. Family training,
4. Trained in-home supports to support families in providing structured activities,
5. Financial supports to assist the family in meeting the excess costs associated with equipment, supplies and environmental modification

The program manager, a member of that local team, and a representative of the state Medicaid agency will authorize the amount / frequency of waiver services. A professional from a licensed Developmental Disabilities provider will facilitate the development of the PCSP and coordinate its implementation. Families will self direct trained in-home supports and venders supplying equipment, supplies, and environmental modification with the assistance of a fiscal agent.

The fee for service model will be used for Provider directed services. Participant Directed services will be reimbursed at the usual and customary rate up to the individual budget limit. Payment rates will be noted on the Individual Authorization templates that the DD Program Manager reviews with the family prior to each authorization period.

Service	Agency Directed	Family Directed	Fiscal Agent cuts check for
Intervention Coor	x		
Environmental Modification		x	Vendor
Equipment and Supplies	x		Vendor
In-Home Support	x		Employee

All service will be authorized via an individual authorization. Frequency of Intervention Coordination's four activities will be on one authorization that is agreed to by family and Licensed Provider. The three self directed supports will be authorized on another authorization form and agreed to by the family.

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/MR.

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
The North Dakota Department of Human Services developed an optional adjustment request (OAR) that was not included in the department budget, but through stakeholder input during the legislative session the funding was allocated and included in the department budget and the department was instructed to develop and submit a waiver to serve this population. Letters of intent were submitted to the four recognized tribes in North Dakota and comments accepted for 90 days.

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: Balsdon

First Name: Debra

Title: Administrator Children and Family Supports

Agency: Developmental Disabilities Division

Address: 1237 W Divide Ave

Address 2: Suite 1A

City: Bismarck

State: North Dakota

Zip: 58501-1208

Phone: (701) 328-8936 **Ext:** ☐ **TTY**

Fax: (701) 328-8969

E-mail: dbalsdon@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: Tina Bay

State Medicaid Director or Designee

Submission Date: Oct 14, 2010

Last Name: Anderson

First Name: Maggie

Title: Director

Agency: Medical Services Division

Address: 600 E. Boulevard Avenue #325

Address 2:

City: Bismarck

State: North Dakota

Zip: 58505-0250

Phone: (701) 328-1603

Fax: (701) 328-1544

E-mail: manderson@nd.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Families of infants and toddlers eligible for the traditional waiver 0037 will have the option of transferring to the ASD waiver if they are eligible for both waivers. If the family chooses to transfer, Development Disabilities Program Management and Infant Development staff will remain the same assuring a seamless transition.

When the child is no longer eligible for the ASD birth through four waiver, the Person Centered Service Plan will include transition outcomes that will identify available support options such as state plan services, traditional developmental disabilities service waiver 0037 or developmental disabilities self directed wavier 0421, supports available through private agencies and informal family support organizations. If slots are not available in the Traditional 0037 waiver or the Self Directed Supports 0421 waiver the childs name will be placed on the waiting list of the waiver or waivers the family wishes to access..

Transition from infant development supports to preschool services will follow the guidelines jointly developed by the Department of Human Services and the Department of Public Instruction.

To support families during the time of transition from the waiver, DD Program Managers and Intervention Coordinators will work with the family to develop a Transition Plan within the Person Centered Service Plan. The plan must address how the child, family and receiving agency will be supported during the time of change. For children approaching their 5th Birthday the assigned personnel within the school system will be critical in providing continuity for the family and will be invited to Person Centered Service Plan meetings with the families consent. DD Program Managers will work with the family to determine if they qualify for supports in other waivers and explore generic supports within the family's community.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the State Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Developmental Disabilities
(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 DD Division and Medical Services. The DD Division, which is a division within the single Medicaid Agency, is responsible for the daily administration and supervision of the waiver, as well as issues, policies, rules and regulations related to the waiver. Oversight of waiver activities is assured through the Department's quarterly waiver coordination meetings which include representatives from Medical Services and units administering waivers.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

Contract for Fiscal Agent services to support Self Directed activities.The Fiscal Agent will execute Provider agreements with vendors of environmental modifications or equipment and supplies.

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

Appendix A: Waiver Administration and Operation

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

   - **Not applicable**
   - **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:
     - **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   The ND Department of Human Services, Developmental Disabilities Division, will monitor the Fiscal Agent contract per department contract oversight protocol.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   Fiscal Agent activities will be continually monitored by families and DDPMs through on-line individual balance sheet reports. Feedback will be solicited from staff working with the Fiscal Agent to measure satisfaction with the current contractor. The Department of Human Services will also monitor monthly contract billings.

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

   Annually, a survey will be mailed to all families to assess satisfaction with supports received through this waiver.A survey will be mailed to all parents/legal decision makers currently receiving waiver services or who have received waiver services within the last 12 months. All surveys will be mailed at one time and follow-up surveys mailed if a response has not been received within 3 weeks of the first mailing. Surveys will be mailed and tracked through DHS Central Office administrators.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Performance Measure:
(A-1) 100% of all participants enrolled will have Level of Care evaluation completed within 45 days of referral by the program manager.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ASSIST Queries relative to participant enrollment, level of care evaluations, participant service plans, and the prior authorization of Waiver Services.

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:
(A-2) 100% of all contracted fiscal providers will carry out operational and administrational functions pertained within this waiver, and the scope of thier contract.

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

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Patterns of errors will be analyzed to determine if they are the result of individual, region, or systemic issues. The Regional DD Program Administrators will address individual issues and regional training needs. The DD Division is available to assist Regional DD Program Administrators as well as addressing systemic issues.

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
◉ Mental Retardation or Developmental Disability, or Both					
	☑	Autism	0	4	☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Mental Illness					
	☑	Mental Illness			
	☑	Serious Emotional Disturbance			

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

The state limits this waiver to individuals on the Autism Spectrum as diagnosed/concurred by a team identified by the state (Evaluation and Diagnostic Team - EDT).The state further limits this waiver to families that agree to self direct In-Home Supports, Equipment and Supplies, and Environmental Modifications.

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Families will be made aware of the maximum age limit and duration upon enrollment. The DDPM will coordinate with the Part B 619 program to facilitate a smooth transition to kindergarten and by the child's third birthday will make the family aware of other support options including the traditional DD waiver, state plan services, self directed supports, Buy In Program, CHIPS, and other informal supports available within their communities. Six months prior to the child exiting this waiver, their person centered service plan will contain a transition outcomes and activities.

Appendix B: Participant Access and Eligibility

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

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

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage: [ ]

○ **Other**

Specify:

[ ]

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

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

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

    Specify the formula:

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

  Specify percent:
- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- **Other safeguard(s)**

  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	30
Year 2	30
Year 3	30

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	

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:

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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)

- [x] **Low income families with children as provided in §1931 of the Act**
- [ ] **SSI recipients**
- [x] **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)**
- [x] **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)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

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

Select one:

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

Specify percentage amount: [ ]

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

Specify:

[ ]

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

DD program managers at the regional human service centers. The minimum qualifications for DD program managers require that they meet the criteria for qualified MR professional, QMRP.

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

Individuals that may be eligible for ICF/MR level of care include individuals with diagnosis of mental retardation as defined in ND Administrative Code 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009 with accompanying cognitive limitations, and who are eligible for Medicaid. The evaluation instrument used to determine whether an individual meets the minimum criteria for ICF/MR level of care is a component of an automated system and is used to assess individual strengths and needs to assist in the determination of eligibility as well as evaluation of level of care. The individual assessment describes the DSM IV diagnosis on Axis I, II, and III and the level of supports needed by a child (less than three years of age in the following areas, residential, day service, motor skills, independent living, social, cognitive, communication, and adaptive skills, behavior, medical and legal. Once the evaluation is complete, an indicator is electronically derived from the scores in the evaluation that determines whether an individual meets the basic criteria for the ICF/MR level of care. The HCBS indicator, in conjunction with the professional judgment of the Program Manager, will serve as the basis as to whether the individual will be screened for waiver services. If the HCBS indicator is "N" (no), the individual cannot be screened to the ICF/MR Level of Care. If the HCBS indicator is "Y" (yes), the individual may be screened. If the HCBS indicator is "P" (professional judgment), the DD program manager will apply professional judgment, utilizing the Guidelines for ICF/MR Level of Care Screenings (DDD-PI-090) to determine if the individual can be screened.

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

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

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

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

The DDPM will obtain all relevant information to include information from the Evaluation and Diagnostic Team (EDT.The data is entered into the automated system to determine if the minimum criteria are met for level of care. If the finding is affirmative, the DD Program Manager will complete the Case Action Form to document the level of care for the MMIS payment system. If it is determined the individual does not meet the level of care, the family will be notified of their right to appeal the adverse decision. The level of care criteria used for the re-evaluation is the same criteria applied for the initial level of care. The DDPM will complete the evaluation based on the most current assessment information available and an interview with the individual and/or those who know the person best. The re-evaluation does not require an updated psychological assessment if the diagnosis has been confirmed, unless it is determined that a new assessment will be beneficial or is needed. The information is entered into the automated system to determine if the minimum criteria is met for level of care and continued enrollment in waiver services.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

When the individual evaluation is completed and activated within the automated system, a system generated Alert due date is calculated to plus one year minus one day to ensure that the re-evaluation of Level of Care is performed on a timely basis. The DDPM and their supervisors have the ability to review all alerts by manager assigned caseload, due date, type of alert, individual case.

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

Documentation of the Level of Care Evaluations/Reevaluations is maintained electronically for each individual for a minimum of 3 years+ in the automated system application which can be accessed at the Regional Human Service Center or DD Division. The MMIS system also maintains a record/history of level of care determinations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

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

Performance Measure:
100% of new waiver enrollees will recieve a Level of Care determination within 45 days by the program manager being assigned to the child.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Query of data from Assist database.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
100% compliance with completion of ICF/MR Level of Care entered into Assist program within 45 days of completion of intake with family by program manager.

Data Source (Select one):
Other
If 'Other' is selected, specify:
query of data from Assist database

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

Data Aggregation and Analysis:

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

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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

Performance Measure:
100% of all waiver recipients will recieve a Level of Care one year minus a day from previous Level of Care.

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

Performance Measures

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

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

Performance Measure:
100% of waiver participants have accurately completed level of care determinations by a Developmental Disability Program Manager.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Queries from ASSIST data base.

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

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 Disability Division Claims Auditor completes a weekly query from the Assist system to determine if the claims being processed have a current Level of Care, if they do she will authorize continued processing of the claim, if not then the claim is denied and the correct code is processed on teh remittance advice sheet sent back to the provider.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Patterns of errors will be analyzed quarterly to determine if they are the result of individual, region, or systemic issues. The Regional DD Program Administrators will address individual issues and Regional training needs. The DD Division is available to assist Regional DD Program Administrators as well as addressing systemic issues.

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

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

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

◉ No
○ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals eligible for the waiver will be provided with a choice of institutional or HCBS services, feasible alternatives under available waivers will be explained by the DD Program Manager and a description of roles and responsibilities regarding Self Directing will be provided to the individual and/or legal representative. The individual choice will be documented on the Individual Service Plan. This information will be provided at the time of waiver eligibility determination and annually thereafter

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

The signed Person Centered Service Plan is maintained in the families file at the Regional Human Service Center following the Department of Human Services retention policy that states information will be kept for 12 years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
When families are unable to independently communicate with the DD Division staff, their DDPM or Administrator, or the Fiscal Agent, the services of an interpreter will be arranged. Written material may also be modified for non-English speaking consumers. The North Dakota Department of Human Services has a Limited English Proficiency Implementation Plan to assist staff in communicating with all families.

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		
Other Service	Environmental Modifications		
Other Service	Equipment & Supplies		
Other Service	In Home Supports		
Other Service	Intervention Coordination		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

Service Definition *(Scope):*

Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned by the participant or their family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the inspection of installation activities and the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant.

Items that are not of direct or remedial benefit to the participant are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant or his/her family must own any equipment that is repaired.

Covered Modifications are:

(1) Ramps and Portable Ramps
(2) Grab Bars
(3) Handrails
(4) Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside a participant's home
(5) Porch stair lifts
(6) Modifications and/or additions to bathroom facilities
a) Roll in shower
b) Sink modifications
c) Bathtub modifications/grab bars
d) Toilet modifications
e) Water faucet controls
(7) Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
(8) Specialized accessibility/safety adaptations/additions
a) Electrical wiring
b) Fire/safety adaptations, including alarms
c) Shatterproof windows
d) Floor coverings for ease of ambulation
e) Modifications to meet egress regulations
f) Automatic door openers/doorbells
g) Voice activated, light activated, motor activated electronic devices to control the participant's home environment
h) Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
i) Stationary built in therapeutic tables

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered. Equipment or supplies purchased for exclusive use at the school/home school are not covered. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle or lease itself. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

Covered Modifications are:

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered. Relatives constructing or installing items covered through this waiver service may not be living in the same home of the individual. Up to $5,200 per state fiscal year will be the limit for Environmental Modifications unless an exception is requested from the DD Division. Exceptions will be given only when institutionalzation is likely and the exception will be limited to 3 months.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify)*:
None
Certificate *(specify)*:
None
Other Standard *(specify)*:
Families along with Person Centered Service Plan team members will identify the appropriate Environmental Supports and Modifications within the Person Centered Service Plan. In Addition to identifying the appropriate environmental supports or modification, the Person Centered Service Plan Team will determine if the adaptations can be made by family members, i.e. a father building a ramp according to ADA specifications. In those specific circumstances the families will obtain the specified material from an individual who is enrolled as a vendor with the Fiscal Agent.

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

Families along with Person Centered Service Plan team members will identify the appropriate Environmental Supports and Modifications within the Person Centered Plan. The families will obtain the material from a vendor who is enrolled with the Fiscal Agent.

As applicable: building permits, bonded and licensed to practice profession, enrolled with Secretary of State, and in

good standing with Workforce Sefety. American's with Disabilities Act guidelines will be followed.

The vendor must provide the item approved in Person Centered Plan, or recommended by a licensed professional, and selected by individual or legal decision maker as cost effective.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Agend and Program Manager

Frequency of Verification:
Prior to modifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Equipment & Supplies

Service Definition *(Scope):*
Funds may be accessed to meet the excess disability related expenses associated with maintaining an eligible consumer in their home. Equipment and Supplies enable an individual living with a primary caregiver, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the Items reimbursed with waiver funds will not duplicate those available under the state plan:
Examples of Equipment and Supplies not included in the Medicaid State Plan include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. 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) coordination and use of necessary therapies, interventions, or services with assistive technology devices, 5) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 6) 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; and (e) Personal Emergency Response System is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep and maintenance of devices/systems are provided.

Items reimbursed with waiver funds will not duplicate those available under the state plan. Equipment and supplies purchased with waiver funds will exclude those items that are not of direct benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

The vendor must provide the item approved in the Person Centered Plan and selected by parent or legal guardian as cost effective. For durable equipment not covered in state plan the vendor must offer the specific item recommended by a licensed professional.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Up to $5,200 per state fiscal year will be the limit for Equipment and Supplies unless an exception is requested from the DD Division. Exceptions will be given only when institutionalzation is likely and the exception will be limited to 3 months.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Equipment & Supplies

Provider Category:
Individual

Provider Type:
Individual

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Families along with Person Centered Service Plan team members will identify the appropriate Equipment and Supplies within the Person Centered Service Plan. In addition to identifying the appropriate Equipment and Supplies, the Person Centered Service Plan Team will determine if Equipment and Supplies that need to be installed can be installed by family members, i.e. a father installing an alarm system. In those specific circumstances the families will obtain the specified material from an individual/company who is enrolled as a vendor with the Fiscal Agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
DD Program Manager

Frequency of Verification:
Quarterly or as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
In Home Supports
Service Definition *(Scope)*:
In-Home Supports (IHS) enable an individual with a disability to remain in and be supported in their family home and community. IHS is intended to support both the family member with a disability and to permit the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible client must be living with their primary caregiver. IHS benefits the eligible client by supporting their primary caregiver in meeting the needs of the eligible client within their daily and community routines. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes; and aid involvement in family routines and participation in community experiences and activities. Families then have the flexibility to use IHS support when they are present(additional support to care out intervention strategies and meet their child's needs or when they are absent(for Respite).

IHS is available while the primary caregiver is present or absent due to work or school. IHS is also available to provide the primary caregiver temporary relief from the demands of supporting their family member with a disability (Respite). The eligible client will be supported in the home in which they live or in the home of the relief care provider if the home is approved by the family.

Employees hired by families for IHS will have back ground checks completed by the Fiscal Agent.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Hours of support will be limited to an average of 150 hours per month over a quarter, unless an exception is approved by the Developmental Disability Division as preventing imminent institutionalization and the exception is anticipated to be needed for less than 3 months.
Individuals providing IHS may not live in the same home as the eligible individual.
IHS supports will not be delivered in a group setting.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Supports

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify)*:
According to NDAC 75-04-01
Certificate *(specify)*:

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DD Division

Frequency of Verification:
Anually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Supports

Provider Category:
Individual

Provider Type:
Individial

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As required by person centered plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal agent.

Frequency of Verification:
Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Intervention Coordination

Service Definition *(Scope):*
Intervention Coordination is a home-based, family focused service that provides information, support and training to assist families and other caregivers in maximizing the eligible child's development. Early intervention professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. All interventions must be based on research with applicable populations.
The Intervention Coordination service delivery model is based on research showing that young children learn through natural learning opportunities that occur throughout the day.
Programs providing Intervention Coordination must provide services according to the prescribed delivery model and cannot offer other models, including direct therapy to young children.
Intervention Coordination works with the family to develop and modify day to day support and intervention activities, design

data collection techniques, and train families and In-Home Support staff in implementing research based interventions with fidelity. Intervention Coordinators will provide the coaching assistance through home visits, review data and update criteria and intervention activities as needed but at least every 3 months, arrange for discipline specific consultations and complete annual assessments to measure developmental domains, especially communication, social/emotional and behavioral.Intervention Coordinators will coordinate with special education pre-schools (IDEA Part B 619 providers) to assure coordination between educational methods employed in the school setting and techniques that support the child in the family home and community.Intervention Coordination services for 3 and 4 year old children will not address educational issues. Children 3 and 4 years of age receiving waiver services will have a PCSP and an IEP which will address their educational needs.Intervention Coordinators will coordinate with special education pre-schools (IDEA Part B 619 providers) to assure coordination between educational methods employed in the school setting and techniques that support the child in the family home and community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Four specific activities within Intervention Coordination will be reimbursed. They include Assessment, PSCP Criteria and Activities/Methods Development, Home Visits, and Consultation.

Assessment includes Initial, Annual and Exit Child Progress Assessment Reviews (PAR) and Annual Developmental Assessments. Assessments must be conducted by at least two qualified staff from two different disciplines (OT, PT, SLP, ECSE, Social Work or Nursing) and identify strentghs and challenges in all domain areas. The family assessment and interview must identify routines, concerns, priorities and resources. Annual Assessments also include completion of the standardized Risk Assessment tool, family interview and development of Emergency Back-up Plans. Prior to transition points additional assessments may be required to assist the team in planning a smooth transition.

Initial Outcomes within the Person Centered Service Plan will be developed by DD Program Managers. Intervention Coordinators will develop the criteria and activities/methods that will implement research based techniques. Initial and Annual PCSP will be developed with all PCSP team members. Quarterly PCSP reviews will be conducted with PCSP Team members selected at the Inital or Annual PCSP to determine if progress is occuring. Includes scheduling meeting two months in advance, sending prior notice, and distributing developmental assessment results 2 weeks before meeting and rescheduling as needed. PCSP document will be completed within 10 working days after the meeting to develop the plan and comply with all requirements of PCSP Checklist. If the data is not showing progress at the quarterly review, the Outcomes, intervention strategies, and/or frequency of supports must be modified.

Home Visits include the Home Visit conducted by the Primary Early Intervention Professional (PEIP) and will support the natural learning opportunities within family and community routines. The PEIP will assist the family and any In-Home Support staff employed by the family in developing the skills needed to consistently carry out the child's PCSP, identifying routines in which to embed interventions to support Social/Emotional, communicative and behavior development. 'Home Visits' may occur in the family home, childcare setting or other community environments natural for same age peers without developmental delays of disabilities. The PCSP team will determine the frequency of home visits. Home Visits must be scheduled for at least once a month, but may be scheduled for multiple times a week. The frequency of the Home Visits should change based on the needs of the child and family.

Consultation includes Face-to-Face Consultation with caregivers and PEIP to address identified consultation questions. Consultation may be conducted in person, by interactive real time consultation with caregiver and PEIP utilizing Webcam, or review of video. When the family is not present they must be connected via phone. Consultation must be completed by qualified OT, PT, SLP, ECSE, Social Worker or Nurse not assigned as the PEIP. Does not include activities conducted by EDT.

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: Intervention Coordination

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
Licensed according to NDAC 75-04-01 which defines Infant Development licensure requirements. Providers of Intervention Coordination must be licensed to provide Infant Development. Currently at least one provider is licensed in each region and another is licensed statewide. Other qualified providers who request licensure and meet the requirements will be licensed.
Certificate *(specify):*

Other Standard *(specify):*
Intervention Coordination programs must provide services according to the prescribed delivery model and cannot offer other models, including direct therapy to infants and toddlers.

The prescribed service delivery model is based on research showing Intervention Coordination services are a home-based, family focused service that provides information, support and training to assist families in maximizing their child's development. Intervention Coordination professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines.
Verification of Provider Qualifications
Entity Responsible for Verification:
DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

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

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

Appendix C: Participant Services

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

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

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

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

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

As provided by NDAC 75-04-05 and DDD-PI-086, criminal background checks must be conducted on all prospective employees of licensed DD provider agencies who may have direct access to individuals served. This includes direct care positions, administrative positions, and other support positions that have contact with individuals served. When prospective employees have lived in North Dakota for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.

The DD Division reviews any record of a criminal conviction of an applicant to determine if according to NDCC 12.1-33-02.1 the individual is eligible to be considered for employment by a licensed DD provider.

Upon annual application for license renewal, the applicant agency must submit a listing of each current employee with a criminal record and date and nature of the offense. Those listings are checked against reports to the Division to determine if in fact the provider had submitted the record for review by the Division prior to assuming duties in direct contact with individuals served.

Employees hired by families for In-Home Support will have background checks completed by the Fiscal Agent.

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):

DDD-PI-086 also requires that providers conduct a check of the Child Abuse and Neglect Registry for each employee hired. The Child Abuse and Neglect Registry are maintained by the ND Department of Human Services Children and Family Services Division. An abuse registry is not maintained specifically for providers of waiver services.

Appendix C: Participant Services

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.*

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

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

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

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

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

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

- **Other policy.**

Specify:

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
(C-1) 100% of providers will meet licensure /certification of agency beyond first year of waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Licensure Data Base

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

Data Aggregation and Analysis:

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

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

Performance Measure:
100% of providers will be reviewed annually for compliance with licensure requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
provider licensure data base

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

Data Aggregation and Analysis:

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

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

Performance Measure:
100% of providers caring for children will have timely criminal background and registery checks.

Data Source (Select one):
Other
If 'Other' is selected, specify:
provider licensure data base.

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

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
(C-2) The Fiscal Agent will assure that 100% of non-licensed or non-certified vendors receiving payment will meet qualifications specified in this waiver.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
(C-3) Quarterly the Developmental Disability Program Manager will review the unique provider qualification as stated in the Personal Centered Plan.

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual Provider issues will be dealt in accordance with NDAC 75-04-01 and training issues per DD Division Policy. When licensing deficiencies are discovered, specific plans of correction will be required in order to maintain licensure standards.

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

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

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

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
To track the amount of services authorized for services that have a cap based on the duration of the waiver, the authorization database will be updated to track the amount authorized and utilized to prevent over-expenditure. This process is currently being handled by staff in the Developmental Disability Division manually inserting the data into the next years' data base. once the statewide DD data base is updated the system will do this automatically.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Person Centered Service Plan/Individual Family Support Plan

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

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

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

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

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

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

The Program Managers who develop Person Centered Plans for Self Directed Supports must be Qualified Mental Retardation Professionals (QMRP).

☐ **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:*

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The DDPM will inform the client and family of their right to be involved in the development of the Person Centered Service Plan, and their right to choose who can be involved in assessment and program plan development. They will also be given the opportunity to choose the time and location of meetings, and the makeup of team membership.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The DD Program Manager (DDPM) initiates service plan development at the time of enrollment with the family. The DDPM will complete the Progress Assessment Review (PAR) to help identify the individual's specific areas of strengths and needs. A Risk Assessment checklist will also be completed with the family to identify potential risks to the individual and how the risks are currently being addressed. The DDPM will assist the family in identifying outcomes (what is important to the individual, what it is they want and why) and will also inform them of Medicaid funded services that may assist them in achieving their identified outcomes and assist in the referral and access to services. The DDPM will explain and provide written information to the family regarding institutional vs. home and community based services; waiver options; and roles and responsibilities of self directing supports. The DDPM will document the individual's identified outcomes and requested services in the Case Plan in ASSIST. The Case Plan will also include other services, including the amount and frequency and other supports the individual is currently receiving, regardless of funding source. The family will be given their choice of waiver services. If the individual is denied a choice of HCBS services the family/legal guardian will be informed of their opportunity to request a Fair Hearing.

A Person Centered Plan will be developed before waiver services are authorized and at least annually thereafter (year minus one day). A Person Centered Service Plan Checklist describing the necessary components of the PCSP, will be utilized statewide for the development of each waiver participant service plan. The checklist describes the areas that need to be assessed and addressed in the plan, including health care needs and mitigation of identified risks. The plan is developed to identify the needs of the individual and to devise ways to meet those needs. The team will always include the family, family members, friends or advocates chosen by the individual, and DD program manager. Staff members who work most closely with the individual providing direct support and care, and know the individual best may also be invited to participate. The Person Centered Plan will be finalized by the DDPM and when approved by the family, distributed to other team members. The DDPM will complete the preauthorization (ISP and Self Directed Support Authorization)) of home and community based services in the Case Plan (by activating the Case Plan). The preauthorization will be entered into MMIS for billing purposes. The DDPM will print a copy of the Case Plan and also ISP which lists the services, amount and frequency of services, and start and end date for each service. A copy of the Case Plan, ISP, and a copy of the PCSP will be sent to the family and the Fiscal Agent. The following rights are printed on the ISP and the signature of the family on the ISP indicates that they have: a) Received a copy of their rights and understand them; b) Been informed of their right to request a change of DD Program Manager; c) Been informed of Protection and Advocacy Services; d) Been informed of their right to select institutional services or waiver services (if the ICF/MR level of care is met); e) Been informed of their right to a choice of service provider(s); f) Received information regarding their right to appeal; g) are in agreement with the services listed on the ISP; h) understand that for services requiring Title XIX funding they must maintain Medicaid eligibility or private pay for those services.

The DDPM is responsible for in depth monitoring that will consist of a face to face visit with the waiver participant and a contact with the family every 90 days to review quality and satisfaction with services, to assure services are delivered as required and remain appropriate for the individual. In depth monitoring by the DDPM will also include of review of individual records, monthly data collection relative to the plan, provider progress notes regarding significant events contained in the monthly update, review of incident

reports from the quarter and verification that recommendations generated to prevent reoccurrence were implemented and effective. The DDPM will share the results and findings of the monitoring with the family and service provider(s) at the time of the Quality Enhancement Review visit. Identified areas of concern will be addressed in an action plan developed by the service provider and DDPM. The results and findings of the in-depth monitoring will be documented in the ASSIST electronic database and will be printed and distributed every 6 months.

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

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

The content of the plan needs to include the type, amount, cost, and frequency of services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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.

If the family wishes to explore the option of co-employer, they will be given a list of qualified providers of waiver services. The DDPM will share information regarding local staff recruitment options and material specifically developed for Self Directed Supports.

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):

DD Program Managers will facilitate the Person Centered Planning Meeting and within two weeks of the meeting, send the final draft of the plan to the family. The individually authorized services will be reviewed and approved by the Regional DD Program Administrator and DD Division. Once the authorizations are approved, the DDPM will complete the Case Plan in ASSIST, which lists all waiver and other services regardless of funding source, amount, scope, and frequency. A copy of the authorization will be sent to the Fiscal Agent. Approval of the plan will be indicated by the signature of the family and DDPM.

When waiver consumers receive In-Home Supports, the DDPM will incorporate the assessment and outcome information provided by Family Support Service providers into a Person Centered Plan within ASSIST.

DD Program Managers as employees of the Department of Human Services represents the Medicaid Agency.

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

b. **Monitoring Safeguards.** *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
(D-1) 100% of personal service plans will include strategies to mitigate risks identified through the risk assessment process established.

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**

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

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

Performance Measures

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

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

Performance Measure:
(D-2) 100% of Person Centered Service Plans will meet State requirements identified in the Person Centered Planning Requirements Checklist.

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

Performance Measures

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

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

Performance Measure:
100% of Person Centered Service Plans will be updated annually.

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:

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

Performance Measures

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

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

Performance Measure:

(D-4) Every six months Development Disability Program Manager will audit 100% of individual authorizations and update authorization so it reflects the actual amount and frequency of services delivered.

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: 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: Updated authorizations that reflect actual supports delivered will be reviewed every six months, annually MMIS reports will be reviewed to assure only actual supports were billed and paid

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

Performance Measures

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

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

Performance Measure:
(D-5) 100% of participants will have a signed statement, per ISP, in their case file stating that their rights have been explained to them.

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**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DDPM is responsible to assure that the Person Centered Service Plan (PCSP) contains the requirements set forth by the State. The approval allows payment to occur for authorized waiver services. The Fiscal Agent will not be able to bill until approval is completed.

The Quality Enhancement Review includes a 90 day face-to-face visit with the participant, record review of program implementation, verification of incident remediation and consumer satisfaction. Contact will also be made with the legal decision maker if applicable. PCSPs will be revised or modified as needed based on review.

The DD Division reviews DD Program Management at each Regional Human Service Center every two years. Case reviews are completed to assure compliance with all requirements for the PCSP. Failure to meet policy requirements will result in Human Service Center licensure corrective action.

ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Participants determine the vendors/providers from whom they will purchase services and supports. They will also negotiate the cost. Participants will have the opportunity to determine their priorities within the waiver budget limitations. DD Program Managers and Fiscal Agent staff will support participants as they self direct. Information regarding risk and responsibility involved in self direction, recommendations and considerations when selecting a vendor is provided in writing for participants and the material is reviewed with them. Guidance regarding key decisions and assistance in prioritizing needs will also be offered.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Participants considering Participant Directed Supports, upon enrollment and annually, DD Program Managers review written information with families regarding:
a. Describes benefits and potential liabilities associated with participant direction of services;
b. Responsibilities of participants;
c. Support available through DD Program Managers and the Fiscal Agent;
d. Component of a Person Centered Plan and their responsibility in its development;
e. Information available on the Fiscal Agent's website.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Equipment & Supplies	☐	☑
Environmental Modifications	☐	☑
In Home Supports	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

Contract entity.

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

Monthly fee for service.

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

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

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

Specify:

Payment to vendors for environmental modification and equipment and supplies.

Supports furnished when the participant exercises budget authority:

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

Specify:

Maintain a secure FTP website that allows DD Program Managers to track participant's budget and expenditures.

Additional functions/activities:

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

Specify:

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

The performance of the Fiscal Agent is reviewed by the DDPM with the family during a quarterly meeting, any concerns are documented in the Quality Enhancement Review document that is forwarded to the Regional DD Program Administrator and Central Office staff, if the issue cannot be resolved by the DD Program Manager and family. DD Division has frequent (at least every quarter) conference calls with the contracted Fiscal Agent to review issues identified through data analysis of Quality Enhancement Reviews. The authorization process prevents over billing by the Fiscal Agent as the MMIS has edits that prohibits payments in excess of authorized budget limits. DD Division Staff monitor monthly budget program spend down reports generated through MMIS and monthly contract billings for Fiscal Agent services. As outlined in the contract with the North Dakota Department of Human Services, the Fiscal Agent also has agreed to have an independent audit conducted and will share the results.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Equipment & Supplies	☐
Intervention Coordination	☐
Environmental Modifications	☐
In Home Supports	☐

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

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

Qualified Mental Retardation Professionals, employed by the Department of Human Services, Regional Human Service Centers, provide support brokerage. This is claimed as an Administrative Activity.

DD Program Managers meet with the families to review information regarding the roles, risks, and responsibilities involved with Self Directing Supports. They connect them to the Fiscal Agent, provide practical skills training to assist them with directing services, assist them with locating sources of waiver goods and services, and developing budget management skills.

In addition to the biennial licensing reviews of the activities of the Regional Program Managers function conducted by the DD Division, the DD Division will review annually the activities of DDPM to assure compliance with all responsibilities and timelines. The reviews will includecompliance with established protocols and policies regarding Support Brokerage activities.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

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

Participants will be informed of availability of representation from the ND Protection and Advocacy Project. If requested, the DDPM will assist participants in accessing services with the ND Protection and Advocacy Project. The ND Protection and Advocacy Project does not furnish other direct services or perform waiver functions.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The DD Program Manager will review the ramifications of voluntary termination, including possible impact on Medicaid and health and safety issues for the eligible family. Other support options including Medicaid State Plan services, other waivers will be explored. The DDPM will assist the family in transition activities. Waiver services will continue during the transition period.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

If the roles and responsibilities identified in the Person Centered Plan are not carried out and it is directly impacting the health and safety of the eligible family, the DDPM will notify the rfamily/legal guardian that services are being terminated and review their right to appeal the termination of services offered through this waiver. Other support options including Medicaid State Plan services and other waivers will be explored. The DDPM will assist the participant in transition activities.

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

Services would only be involuntarily terminated if the parent or legal guardian were unable to self direct services which resulted in a situation that jeopardized the child's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		30
Year 2		30
Year 3		30

Appendix E: Participant Direction of Services

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

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

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

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

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

Providers are licensed through the ND Department of Human Services to provide Family Support Services. Licensed Family Support Service Providers are vendors with the Fiscal Agent. To assure individuals/families maintain control and authority over employees, and that the Family Support Service supports the concepts of self-direction, specific roles and responsibilities are addressed in the Person Centered Plan.

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

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

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

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

Specify how the costs of such investigations are compensated:

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☑ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☑ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

After the Person Centered Service Plan team meets, the DDPM will develop the individualized budget. The budget will be based on the specific support needs of the eligible participant, generic and informal resources available, and risk of unwanted out-of-home placement. Individualized budgets identify the funds that will be available for each budget line item. The amount authorized for other self-directed supports will be negotiated based on anticipated costs. Families will sign all individualized authorizations to indicate their approval and acknowledge their right to appeal. All individualized authorizations are also reviewed by Regional DD Program Administrator and must be approved through the DD Division before services can begin. All authorizations are reviewed after the quarter to audit the authorization back to the actual amount of funds utilized. This information is then considered as the next authorization is developed.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Families will sign all individualized authorizations to indicate their approval of the projected budget and acknowledge their right to appeal. If during the authorization period it becomes necessary to transfer funds from one budget line item to another or if additional funds are needed, the family will request a meeting with their Regional DD Program Manager to re-negotiate their budget.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Changes will be made to the individual authorization if the changes involves increasing activities, hours and dollars to met outcome in Person Centered Service Plan. If the change involves a change in the outcome or the addition of a new outcome both the Person Centered Service Plan and individual authorization will be updated. A copy of all changes will be given to the family and Fiscal Agent and provider as appropriate.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The family will be given notice of their right to a Fair Hearing if they are not given the choice of Home and Community Based Services as an alternative to institutional care, are denied the service(s) of their choice, or the providers(s) of their choice; or whose services are denied, suspended, reduced or terminated. Each service authorization signed by family contains written notice of the right to request a fair hearing, to whom they must address the request, and that services may continue during the process if they request a hearing before the date of action. They are also notified that if the hearing decision is not in their favor, the cost of services provided may be subject to recovery. Notification of Rights at a minimum are provided to each waiver recipient by the DDPM at enrollment, prior to annual Person Centered Service Plan Review, and whenever a recipient registers a concern regarding services.

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

DD Program Managers keep copies of written correspondence regarding Notice of Adverse Actions, signed ISPs and Authorizations at the Regional Human Service Centers.

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

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**

a. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes

addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The ND Department of Human Services assures that a family/legal guardian who is dissatisfied with any decision or action, may request an informal conference in an attempt to resolve the issue. The request for formal conference must be submitted to the Regional Human Service Center Director per DDD-PI-094. The use of informal conference will not preclude or delay the family/legal guardian's right to a fair hearing. Regional DD Program Manager will provide assistance to the grieved family/legal guardian with submitting an informal appeal and to describe the process of appeal.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- ○ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ◉ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

All families must review and sign a Participant's Agreement prior to enrollment in Self Directed Supports. The Participant Agreement includes the reporting requirments for abuse, neglect and exploitation including timelines. The enrollment packet provides information regarding the definitions for abuse, neglect, and exploitation; how to report; and to whom. Families and their employees are mandatory reporters under the Self Directed Supports waiver. A competency packet regarding abuse, neglect, and exploitation is included in the participant and employee agreement with the Fiscal Agent.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or

families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DD Program Managers provide families with written information regarding the "DD Bill of Rights", Century Code 25-01.2 and definitions of abuse and neglect, and exploitation. The information will be presented at a level consistent with the individual's level of understanding and will include contact information to make a report. This information will be provided at the time of waiver enrollment and annually thereafter. The Person Centered Plan will identify the entities responsible for providing the training and the frequency of that training.

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

For individuals birth through four, suspected abuse, neglect, and exploitation is reported to Child Protective Services who is responsible for assessment/investigation and follow up relative to the report.

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

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

The CPS worker must conduct a face-to-face meeting with the child (subject of the report) within the 62 days when abuse and/or neglect is confirmed.

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

The Child Protective Services within the Department of Human Services and its designees receive all reports of abuse, neglect or exploitation of a child. An assigned case worker will then review any and all material pertaining to the report along with personal interviews with identified individuals having any information regarding allegations. This information is given to an intra-disciplinary team of professionals who review and determine if additional services are needed. The whole process is required to begin within 24 hours of receiving the initial report as per outlined in the established guidelines. The Central Office Administrator will follow-up with Child Protective Services regarding all reported incidents concerning status of child and resolution of investigation
Reporters
The reporter brings the concerns of child abuse and neglect to the attention of the CPS agency. The primary responsibility of the reporter is to provide information regarding the alleged child victim(s), the person named as responsible for the child's health and welfare, and the incident(s), which caused a suspicion of child abuse and neglect. In addition, the reporter should be available to the CPS Social Worker for any further questions about the report.
Mandated Reports
The Child Abuse & Neglect Law identifies people mandated to report suspicions of abuse and neglect. This list includes any physician, nurse, dentist, optometrist, medical examiner or coroner, any other medical or mental health professional, religious practitioner of healing arts, school teacher or administrator, school counselor, addiction counselor, Social Worker, child care worker, foster parent, police or law enforcement officer, Juvenile Court personnel, Probation Officer, Division of Juvenile Services employee, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the Department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser.
In order to fall under the mandate and intent of this law, it is not necessary that the child by physically (in the literal sense) before the reporter. Any mandated reporters named in NDCC Section 50-25.1-03, who would have knowledge of or reasonable cause to suspect child abuse or neglect as a result of information provided to them, would be required to report that belief, notwithstanding the fact that the child was not physically present before them. If the information provided to that individual in his or her professional capacity was sufficient to form the basis of a reasonable suspicion that child abuse or neglect had occurred, then that individual would be responsible for reporting that information as required by statute.

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

All reports and findings for serious events and all other incidents reported as abuse, neglect and exploitation are entered into an Incident Management data base maintained by the State DD Division. Data will include information regarding children birth to four years of age from Child Protective Services. The data is reviewed at least quarterly by the State DD Division, Children and Family Services Division and State Protection and Advocacy staff at their quarterly meetings.

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

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

The child protective service worker must conduct a face-to-face meeting with the child (subject of the report) within the 62 days when abuse and/or neglect is confirmed.

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

When challenging behaviors are identified, the Person Centered Services Planning team will identify if additional consultants are needed to conduct a functional behavioral assessment and recommend positive behavior interventions. In the event restraints or seclusion would be appropriate, the plan must be reviewed and approved by a behavior management and human rights committees.

Families and In-Home Support employees will receive information defining restraints and seclusion and their responsibility to report all known incidents of unauthorized restraint and seclusion to Child Protective Services (birth to four).

DD Program Managers have received training on conducting Routines Based Interviews (RBI). RBI techniques will be used to capture a picture of daily issues the family deals with and identify behavior challenges and current responses.

Intervention techniques will be appropriate for the attention span of the child and embedded in the daily routines as research shows young children do not learn through mass trials.Restraints or seclusion will be an exception and must be reviewed prior to implementation by a licensed psychologist and regional Behavior Management and Human Rights Committees to assure all other less restrictive approaches have been implemented and the risk analysis supports the intervention recommended. Data collection and on-going monitoring will also be required.

Seclusion for children less than 5 years of age will be limited to observed time-out not to exceed 3 minutes. Restraint for children less than 5 years of age will be limited to hand over hand or holding to prevent self injurious behavior and limited to duration of child's attempt to cause injury to self.

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

The DD Division will maintain a data base regarding use of restraints and restrictive interventions. The data is reviewed at least quarterly by the State DD Division.

Appendix G: Participant Safeguards

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

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

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

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

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

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

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

When challenging behaviors are identified, the Person Centered Services Planning team will identify if additional consultants are needed to conduct a functional behavioral assessment and recommend positive interventions. In the event restrictive interventions would be appropriate, the plan must be reviewed and approved by a behavior management and human rights committees.

Families and In-Home Support employees will receive information defining restricitive interventions and their responsibility to report all known incidents of unauthorized restraint and seclusion to Child Protective Services.

DD Program Managers have received training on conducting Routines Based Interviews (RBI). RBI techniques will be used to capture a picture of daily issues the family deals with and identify behavior challenges and current responses.

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

The DD Division will maintain a data base regarding use of restraints and restrictive interventions. The data is reviewed at least quarterly by the State DD Division.

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)*

a. 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)*

i. **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).

ii. **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:

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

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

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

Performance Measure:
(G-1) The mortality rate of the served Autism Spectrum Disorder population will be compared to the general area population, by age, and by cause of death will be comparable to national statistics.

Data Source (Select one):
Mortality reviews
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:
(G-2) The incident rate of Child Protective Service investigations involving the served Autism Spectrum Disorder population compared to the general population, by numbers substantiated, by age, by type of incident, living arrangement, and by Autism Diagnosis will be comparable to national statistics.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Child Protection Services data from Children and Family Services Division and demographic information in ASSIST.

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:
(G-3) 100% of participants and/or legal decision makers will report that they have been informed of investigation results.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DD Program Managers will review incident investigations and implementation of recommendations to prevent reoccurrence. If the issue cannot be resolved, the DDPM will inform the DD Program Administrator and DD Division. Quarterly meetings with the Protection and Advocacy Project to address review of incident report trends, and training activities, incident report system policies and procedures.

ii. **Remediation Data Aggregation**

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

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

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

◉ **No**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

The DD Division will aggregate data and analyze the data using charts and other visual depictions when they meet quarterly to review and analyze data for all performance measures. Trends will be identified and grouped in the following areas:
1. Level of Care
2. Service Plan
3. Qualified Provider
4. Health and Welfare
5. Administrative Authority
6. Financial Accountability

If 100% compliance or continuing progress as identified in past corrective action plans has not been made, remediation activities will be modified and prioritized with responsible resources and timelines identified.

All trends and prioritized remediation activity modifications will be reviewed annually or as needed with the DD Advisory Committee and Medicaid Director prior to implementation. Annually, data regarding all performance measures will be made available to all stakeholders and the public, via the Department's website.

This Quality Improvement System will apply to all DD System Waivers, but data will be stratified by waiver. Data will be divided so each waiver can be examined individually.

A. Annual reports will be provided to the Medicaid Director regarding waiver compliance with each assurance.
B. Annual reports will be provided to the North Dakota Protection and Advocacy Project regarding incident management.
C. Annual reports will be provided to the Developmental Disabilities Advisory Committee on all performance measures and progress towards those measures.
D. Annual reports on all performance measures and all progress towards those measures will be made available to the general public on the Department's website.

ii. **System Improvement Activities**

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

b. System Design Changes

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

The effectiveness of system design changes will be evident through ongoing monitoring activities using the established performance measures. Once performance measures are implemented and the DD Division has an initial baseline year of service experience, the DD Division will develop priorities.

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

Based on the review of the Quality Management System, the DD Division will review the following on an annual basis:

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

All self directed service payments are made through a contracted Fiscal Agent. The Fiscal Agent disburses payments for receipts for goods, services and payroll authorized by the individual's service plan. The Fiscal Agent maintains records of all payments and account credits which are available on-line to individuals receiving services, the supports broker, and to the Medicaid agency. Families are made aware of how they can access information through the initial sign up packet which the DD Program Manager reviews with the family. The Dd PRogram Manager reviews actual usage of supports quarterly and updates the individual authorization to reflect actual amount of contract used. The Fiscal Agent bills through the ND MMIS, by participant, monthly for the expenses paid on behalf of each participant. The Fiscal Agent codes each payment according to the type of benefit paid and annually produces a report with total payments for each code. The contract with the fiscal agent requires an ANNUAL independent audit. MMIS data, authorizations and Fiscal Agents fees will be compared every 6 months by the Developmental Disabilities Division to identify and address any discrepancies.

The Fiscal Agent contracted has developed an on-line balance sheet report that indicates total budget, expenditures and remaining funds. This information is available to families and DD Program Managers. If families request, a copy of the balance sheet report is mailed to them monthly or as requested. Families may also call the Fiscal Agent for updated information. Families are made aware of how they can access information through the initial sign up packet which the DD Program Manager reviews with the family. The authorization process prevents over billing by the fiscal agent as the MMIS has edits that prohibit payments in excess of authorized budget limits. Central office staff monitor monthly budget program spend down reports generated through MMIS and monthly contract billings for fiscal agent services. As outlined in the contract with the North Dakota Department of Human Services, the fiscal agent has agreed to have an independent audit conducted annually and will share the results. Annually the DD Division will review compliance of Fiscal Agent with waiver requirements related to fiscal agent duties and review all client financial files to assure financial integrity.

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

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

The State Auditor's Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years. Program Administrators determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). Program Administrators then authorize services on the Person Centered Service Plan in ASSIST.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

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

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

Performance Measure:
(I-1) 100% of the claims are processed through MMIS.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
100% of error claims will be denied payment.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Errors in payments for participants' claims are directed to designated contacts of the fiscal agent or to the support broker. Issues are logged by the Support Broker entity and discussed as an ongoing agenda at monthly meetings of DD Program Administrators and DD state office staff. If there are unresolved issues, DD Division staff meet with Fiscal Agent management to resolve the specific issues and devise procedures to avoid further errors. Those meetings occur approximately quarterly or as needed.

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

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

c. Timelines

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

- ○ No
- ◉ Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The DD Division is participating in the development of the new MMIS System to ensure that all DD Waiver issues are addressed in the new system when it is implemented. Currently claims are being processed in the current billing system with suspended claims being processed manually.

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).

Individual budgets are determined using standardized per hour rates with the number of hours of service determined by assessment of need. Utilizing the Family Support Guidelines, the DDPM assists the family to identify needs of the eligible individual. Sources of assistance to meet those needs, including all natural supports, are identified. The remaining needs are quantified as hours of paid supports. The hourly rates for In-Home Support are from the DD direct service rate schedule (used for all direct services in all DD service waivers) which is determined by audited costs and adjusted according to legislative appropriations. For In-Home Support services, participants may choose to use a different rate but maximum costs are limited to the individual budget. The participant directs the Fiscal Agent as to the actual salaries and costs they want to pay but payments by the Fiscal Agent and billings from the Fiscal Agent to the state cannot exceed the individual budget amounts. Funds are then added for each criminal background check that is expected to be needed. The Fiscal Agent's rates are determined according to a contract awarded as a result of successfully responding to an RFP. The Fiscal Agent fee per month per active participant (current authorization period) is not deducted from the individual budget. The Fiscal Agent fee is billed through the contract system. The fee per back ground check is also added to the individual's authorization, not deducted from their budget.

A number of opportunities are provided for public comment into the rate setting process. Base staffing ratios and allowable costs are stipulated in ND Administrative Code 75-04-05 which is promulgated through a public notice and hearing process as required by state law. The public notification list and comment solicitation for rules governing rate setting for the Waiver include a variety of stakeholders including the Arc-ND, Protection & Advocacy, Disabilities Consortium, DD Advisory Committee, DD service providers, legislators, other stakeholders and the general public. Salary and fringe costs and inflationary adjustments are determined by legislative appropriation and is subject to that public process. In addition, the DD Division participates in the Legislative Partnership Committee, a planning group--represented by the entities listed above plus other interested persons—that develops a legislative priorities agenda which includes rates and rate setting issues.

Time data was collected from all Infant Development providers to determine the amount of time required for each of the 4 activities. The average number of occurrences per year was then determined. That information was then combined with audit data to determine the fee for each activity. Because time per activity was factored into the formula to determine that rate the fee is paid per product from each activity. A home visit is paid for when a standardized Home Visit contact note is recorded in Lotus Notes. The product for a consultation is a report that defines the question for the consultant and their response. A product is also the measurement for and PCSP and Assessment. The DD Program Manager develops the general outcomes for the PCSP, but the Intervention Coordinator develops and supports the day to day intervention activities. The assessment completed by Intervention Coordinator looks at all developmental domains and measures strengths and challenges within the family and community routines. The DD Program Manager 'assesses' the support needs of the child and family.

Parents/Legal Discussion Makers are aware of service costs and individual budget amounts through the individual authorizations.

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:

Services are paid by a Fiscal Agent as directed by the participant. The Fiscal Agent then bills MMIS monthly with a different service code for each of the self directed supports (In-Home Support, Environmental Modifications amd Equipment and Supplies).
The DD Billing Manual is reviewed with the fiscal agent and the DD Claims Auditor is available to answer any questions they may have.

Currently the Fiscal Agent contract is with Acumen. A Request for Proposals will be developed to determine what agency will be the Fiscal Agent starting April 1, 2011.

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:

DD Program Managers determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). DD Program Managers then authorize services on the Individual Service Plan in ASSIST.

Edits are built into the system to prevent payment for services not authorized.

The DD Claims reviewer receives weekly queries of ASSIST data for individual changes to Level of Care and start or termination of waivered services. The Level of Care determinations are entered into an MMIS file. Only one code can be entered per individual assuring that services cannot be duplicated. The Individual Service Plan information authorizing a waiver service is entered into a DD eligibility file which includes the service authorized, dates for which authorized, provider number and Medicaid number and rate and frequency (for individualized rates). The Fiscal Agent bills for services by client Medicaid number, service code, provider number, dates of service and units of service. Numerous edits assure that claims are paid properly. In order for a claim to be paid for waiver services, the system 1) determines the individual is currently eligible for MA, 2) the person has a current level of care screening and code for DD waiver services, 3) the service is currently authorized by DD program management, 4) the billed rate is correct for that individual, provider, or program, 5) units billed are within authorized amounts, 6) units billed are within maximum allowable, 7) there are no competing claims for the same service and time period.

If any of the above are absent from the system or conflict, the claim will suspend or be denied. The claims reviewer then receives reports of suspended or denied claims and the reason. For Self Directed Supports, DD Program Management completes an individualized authorization document. Through an automated work flow process, this is forwarded to the Regional DD Program Administrator for review and approval and then to the DD state office for review and approval. With final state office approval it is forwarded to the DD Claims reviewer to enter the authorized amount and dates of service, the rate, and authorized provider.

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

- ( ) **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.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

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

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

The same Fiscal Agent (FA) will be used as is used for other self-directed waivers. All self directed supports included in this waiver will be paid through the Fiscal Agent. The FA will assure that payments do not exceed the budget within the individualized authorization, develop and maintain employee files, pay the employees the families have hired, pay the vendors selected by the families, and withhold and report all required state and federal taxes and benefits.

Quarterly, the Regional DDPM will review with the family the amount of services utilized and adjust the budget within the individualized authorization back to actual. Payments that are in excess of what is authorized or are unallowable are recouped from the Fiscal Agent.

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

Acumen responded to the initial Request for Proposal and received a 12 month contract with option of renewal for 5 additional years. A Request for Proposals will be issued for fiscal agent services prior to the end of the current contract which ends 3/31/11.

The DD Billing Manual describes the Web File Transfer method for billing and the DD Claims Auditor is available to answer any questions.

☐ **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: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

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. *Select one:*

The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the 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: