

Par. 1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 525-05, Home and Community Based Services. New language is in red and underlined.

Par. 2. **Effective Date** – April 1, 2022

## **Adult Residential Care 525-05-30-16 (Revised 04/01/22 ML #3685)**

### Purpose

To provide an array of services to an individual in a 24-hr setting. Adult residential programs specialize in care of individuals with chronic moderate to severe memory loss or an individual who has a significant emotional, behavioral, or cognitive impairments. It is also a service in which assistance with ADLs/IADLs, therapeutic, social, and recreational programming is provided. Care must be furnished in a way that fosters the maintenance or improvement in independence of the recipient.

The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

For settings in which landlord tenant laws do not apply, the case manager must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

All adult residential recipients must have a signed lease or other legally enforceable agreement that meets the above standards. A copy of the lease must be maintained in the recipient's file.

Adult Residential Services cannot be provided in any setting that is:

- Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or;
- Located in a building on the grounds of, or immediately adjacent to, a public institution.

### Service Eligibility, Criteria for

The individual receiving Residential Care service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services.
2. Be at least age 18.
3. Must not be severely impaired in eating, transferring, or toileting.
4. Does not have medical or behavioral needs that require professional evaluation and management on an ongoing basis.
5. Need the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building.
  - Community Integration is provided to enable the individual to promote independence and alleviate social anxiety. Some activities to be considered are community social events (such as fairs, sports leagues, church functions), volunteer or paid employment, educational/vocational activities.
  - Social Appropriateness assists the individual with the development of social skills needed to interact with individuals in the facility or in the community. Such activities include (but are not limited to): respecting others' space and privacy, non-offensive communication, obeying laws and rules, timeliness, safety/risk procedures;

Or

Require protective oversight and supervision in a structured environment that is professionally staffed to monitor, evaluate and accommodate an individual's changing needs.

6. ~~Approval from a HCBS Program Administrator is required.~~

A rate of no more than the current maximum room and board rate per month shall be paid to the licensed provider by the recipient for board and room costs. Room and Board is the responsibility of the recipient and not included in the provider's daily rate.

#### Service Tasks

1. This service includes 24-hour, on-site response staff;
2. Transportation may be provided as a component of this service and included in the daily rate paid to providers. Contact a HCBS Program Administrator to determine if transportation has been included in a rate for a specific residential care provider.
3. Assistance with ADLs and IADLs within the guidelines of the Basic Care licensure standards;

4. Allowable service tasks as identified on the ~~Authorization to Provide Medicaid Waiver Services SFN 410. Preauth.~~

#### Limits

Limited to the tasks as in agreement between the Department of Human Services and the Residential Care facility provider and as authorized by the ~~County Social Service Board HCBS~~ Case Manager.

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

Residential Services is an all-inclusive service with the exception of Supported Employment Services for an individual who was determined eligible for Adult Residential Care as a result of a need for the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building.

### **Chore Service 525-05-30-20 (Revised 04/01/2022 ML #3685)**

#### Purpose

The purpose of Chore Service is to complete tasks which an individual is not able to complete in order to maintain their home, lawn, or walkway. The chore service tasks authorized must be directly related to the health and safety of the individual, or maintaining access to safe and appropriate housing.

Chore Service can provide for the completion of one time, intermittent, or occasional home tasks which enable individuals to remain in their homes.

#### Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- Workplace
- Other community service settings

Service Eligibility, Criteria for

The individual receiving Chore Service must meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. For Emergency Response Service, is limited to installation and monthly rental fee. ERS Service is restricted to individuals living alone.
  1. Exception: If an individual resides in a multiple person household and there are occasions when the individual may be at risk due to the absence of the other household member(s), it is allowable to authorize (ERS) as long as the case manager documents the need and benefit to the individual.
3. The individual is not able to complete tasks to maintain his/her residence, lawn, or walkway.
4. The chore activity is a one-time or intermittent task.
5. If the individual is a renter, chore services shall not replace the responsibilities of the landlord to complete tasks to maintain the residence, or walkway.
6. Pre-approval from the Department of Human Services is required if the cost of the service is expected to exceed ~~\$200~~ \$500 per month. See Service Tasks listed below for specific tasks that require additional prior approval.
7. Emergency Response Service is limited to persons cognitively and physically capable of activating the emergency call.

Service Tasks

Professional extermination or sanitation Need prior approval Authorized per job, not units	Snow/Ice removal (when measurable snowfall or drifts present a safety hazard to the individual)
Floor care/cleaning of unusual nature, tacking down loose rugs or tiles Need prior approval	Moving heavy furniture and cleaning on seasonal basis for safety reasons
Cleaning appliances (may include moving to clean around or behind)	Cleaning and garbage removal of unusual nature Need prior approval
Professional ERS installation and monthly rental fees are allowed -- does not include maintenance or repair of ERS	Clean windows (may include seasonal removal of screens or storm windows)
Lawn mowing	

The purpose of this service is to maintain access and prevent any barriers to safe and appropriate housing. The service is not to be utilized for cosmetic purposes, but instead to comply with city ordinances related to grass control.

**Limits:**

Limited to seasonal cutting and trimming grass, bagging/dumping.

Does not include landscaping, fertilizing, or weed control.

Maximum service amount is set at once per week.

If a provider is to use an individual's equipment to complete this task, the individual must sign a statement granting permission. The case manager must maintain this statement in the individual's file.

Providers

Chore Service may be provided by the following individual QSP's or employees of a QSP agency (**checked if allowable**):

- Guardian
- Legally Responsible Person - Legal spouse or parent of a minor child.
- Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.**

**Environmental Modification 525-05-30-25  
(Revised 4/1/22 ML #3685)**

Purpose

The purpose of Environmental Modification Service is to modify a recipient's or family member's home (the recipient must reside in the family home) to enhance the recipient's ability to function as independently as possible in the home or family member's home.

Service Eligibility, Criteria for

The individual receiving Environmental Modification Service must meet the following service eligibility criteria:

7. Must be eligible for the programs of SPED, ExSPED, or Medicaid Waiver for Home and Community Based Services.
8. The recipient or family member must own or rent the home prior to application. If the owner of the property is someone other than the service recipient, the file must include the owner's written approval for the modification, consistent with the property owner's obligations

pursuant to section 804(f)(3)(A) under the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] prior to the installation of the environmental modification.

9. The individual has a need for a safer and/or adapted environment in which to live, such as the installation of grab bars in the individual's bathroom.
10. The home modification must directly facilitate the applicant's/recipient's ability to complete his/her own cares independently or to receive care. It must be evident that without the home modifications, adequate care or the ability to perform self or environmental care is not possible.
11. The benefit outcome of the home modifications must be proportionate to the cost. Factors to consider are: the age of applicant/recipient, life expectancy, the value of the house, the applicant's/recipient's commitment to remain in the home including the family's commitment to assist.
12. Physical adaptations to the home required which are necessary and without which, the recipient would require institutionalization.

### Limits

SPED and ExSPED costs are limited to: maximum monthly cost limit for SPED and ExSPED.

For the Waiver programs see section [Environmental Modification, Scope of](#) which cannot exceed the amount budgeted (per person) for environmental modification in the federally approved Medicaid Waiver for the State of North Dakota.

Modifications are not for routine home maintenance, (such as carpeting and/or floor repair, plumbing repair, roof repair, central air conditioning, appliance repair, electrical repair, etc.) but are to promote independence. Adaptations, which add to the total square footage of the home, are not allowed. All services shall be provided in accordance with applicable state and local building codes.

For environmental modification the dollar limit is the lesser of the highest monthly rate for the highest cost skilled nursing facility or 20% of the tax evaluation of the home. This cap may be increased as determined by legislative action. Exceptions to this service cap will not be made. If the

individual's needs cannot be met within the allowed rate case management would explore other service options with the participant including nursing home placement. The case manager makes participants aware of the service cap.

Funds for this service may only be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a recipient living in their own home or in the home of their family member.

A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the recipient if the estimated cost of the modification is more than \$250500. The cost of the assessment to provide a written recommendation is an allowable expense if the cost of the assessment is not covered under the State Plan. The cost of the evaluation must be included in the cost estimate submitted to the Department and the total cost of the modification and the assessment cannot exceed the current funding cap.

#### Pre-Approval Service Eligibility Determination

Environmental Modification Service requires prior approval from HCBS Program Administration. The following procedure is used in determining service eligibility:

1. The individual must make application for services to the HCBS Case Management Agency in their county of physical residence using "Application for Services" ([SFN 1047](#)).
2. The HCBS Case Management Agency will determine whether or not the need for home modification is related to the care needs of the applicant. The comprehensive assessment is used to identify functional impairments.
3. A visual inspection of the home is completed by the HCBS Case Manager and, whenever possible, a professional of another discipline with experience in evaluating home care needs of the elderly and disabled. They will determine if the applicant's/recipient's request for Environmental Modification Service will be of direct benefit to the applicant's self-care needs. If it is found the requested/proposed modifications will not be of direct benefit to the applicant/recipient, the Department must deny the service request following the service denial policy procedures.

4. If the home is in poor condition and not structurally sound, Environmental Modification will not be approved.
5. A summary of the applicant's/recipient's service request and the recommendation(s) resulting from the home inspection is documented in the case file records. Included in the documentation must be an explanation of the proposed home modifications and how they will enable self-care or enhance care provided by others.
6. Written construction bids must be obtained for any work funded under this service chapter. When the estimated cost exceeds \$500.00, bids must be obtained from at least two licensed general contractors or unlicensed contractor if possible. Exceptions may be made to the two bid requirement if it can be demonstrated that there is a lack of available service providers in the area. All bids must include a breakdown of the labor AND material costs of the modifications. See section 525-05-45 for Contractor Standards.
  - If an unlicensed contractor is providing environmental modification the time and materials of the project may not exceed \$4000.
7. Upon receipt of the written bid(s), the following information is sent to the HCBS program administrator: written bids, narrative explanation of the proposed work and how it will assist the applicant/recipient to complete or receive self-care, a copy of the most recent Comprehensive Assessment, and the Person Centered Plan of Care that lists Environmental Modification Service. If an exception is being requested to the two bid minimum include a written explanation of the facts supporting the request. HCBS Program Administration's decision will be based on this information.
8. If the proposed Environmental Modification Service is not approved, the Case Management Agency will issue a denial notice following the procedures of denying services.
9. After the HCBS Case Management Agency is notified that the environmental modification project is approved, the Case Manager will assist the contractor (awarded the bid) to complete the forms required for enrollment as a Qualified Service Provider. The Authorization to Provide Services is issued to the contractor awarded the bid once the successful bidder has met the requirements of a Qualified Service Provider. The service period dates entered on the Authorization to Provide Service is the time span in which the contractor agrees to finish the project.

10. Upon completion of the home modification, the HCBS Case Manager and the home care professional that participated in the initial home inspection and service recommendations, will inspect the job to determine if it was completed according to the bid. If not, the HCBS program administrator must be contacted immediately. Any cost overruns are the responsibility of the contractor.
11. Upon completion of Environmental Modification Service, a new care plan must be completed, having deleted the reference to Environment Modification Service.

### Environmental Modification, Scope of

The modifications to the home allowed within the scope of this service must be of direct and substantial benefit to the applicant's/recipient's need to perform self-care or receive care from others that cannot be met by the current physical characteristic of a part of the home.

Examples of allowable home modifications include but may not be limited to the following:

12. Labor and materials to widen doorways to accommodate wheelchair.
13. Labor and materials to install a wheelchair ramp when structural changes to the house are required.
14. Labor and materials to install or relocate plumbing and/or electrical systems to accommodate specialized equipment.
15. Labor and materials to modify a bathroom, including installation or relocation of fixtures to accommodate the individual's personal care needs.
16. Labor and materials to modify a kitchen to enable accessibility for independent meal preparation.
17. Adaptations may include the installation of ramps, and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and necessary for the welfare of the recipient.

### Materials Authorized for Purchase

The materials authorized for purchase must be directly related to the health and safety of the individual.

## **Family Personal Care 525-05-30-32** **(Revised 04/01/22 ML#3685)**

### Purpose

The purpose of family personal care (FPC) is to assist individuals to remain with their family members and in their own communities by allowing individuals who want to choose their spouse or one of the following family members as defined under N.D.C.C. 50.06.2-02; parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew, as their family personal care service provider. ~~It provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.~~

### Service Eligibility, Criteria for

The individual receiving Family Personal Care will meet the following criteria:

1. Must be eligible for the HCBS Medicaid Waiver program.
2. The individual and qualified provider (who is a qualified family member and is enrolled as a personal care provider) must reside in the same residence.
  - a. The qualified family member must be one of the relatives as defined in Family Home Care N.D.C.C 50-06.2-02(4), and must be the provider performing the care to the individual. Family Personal Care can be provided by the "spouse or by one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew."
3. Before a legally responsible individual who has decision making authority over an individual can be enrolled as a qualified service provider for Family Personal Care, the Case manager must approve the choice of provider. The case manager is responsible to forward to the HCBS Program Administrator a copy of the narrative that explains why the legally responsible person acting as the family personal care provider is in the best interest of the individual. A legally responsible individual would include a Legal Spouse or Guardian.

4. The individual and qualified provider must mutually agree to the arrangement. The provider indicates their agreeance with the care plan and qualified provider by signing the person-centered plan of care, SFN 1265 or web-based version of the person-centered plan of care.
5. The need for services must fall within the scope of tasks identified on the [SFN 1012](#), Monthly Rate Worksheet - Live-In Care (MRW), and Authorization to Provider Waivered Services.
6. The individual must have a daily need that is included in the Monthly Rate Worksheet.

#### Service Tasks/Activities

The service tasks/activities within the scope of this service chapter are identified on the ~~Authorization to Provide Medicaid Waiver Services form Preauth~~, and only those tasks/activities listed on the SFN 1012, Monthly Rate Worksheet, can be approved and authorized.

Tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service activity benefits the individual.

The department may pay a provider for homemaker tasks that would otherwise be considered the individual's share of the responsibility to complete the task. An example of this would be authorizing housekeeping for the individual's personal private space OR their shared responsibility of cleaning the common living space.

#### Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
  - Workplace
- ✓ **Other community service settings**

#### Out-of-Home Care

Payment can be made for days the individual is receiving the SAME care from the SAME caregiver-QSP although not in the home they otherwise mutually share. No payment is allowed for individuals out-of-state with the exception of individuals seeking medical care out of state unless prior approval has been given by an HCBS Program Administrator.

For care out of state, prior approval must be granted from the HCBS Program Administrator.

#### Provider need not be Present in the Home on a 24-Hour Basis

This provision within the Family Personal Care service is appropriate for individuals who can be left alone for routine temporary periods of time (e.g. part-time employment of the qualified family member) without adverse impact to the individual's welfare and safety. The individual must agree to be left alone.

- This provision does NOT allow for the qualified family member to hire a provider to provide care for the individual during routine absences from the home.

### Limitations

Family Personal Care cannot be combined with adult residential care, adult foster care, extended personal care, and transitional living.

### Providers

Family Personal Care is provided by the live-in qualified family member. The family member may also have the following relationship to the eligible individual (**checked if allowable**):

- ✓ **Guardian**
- ✓ **Legally Responsible Person - Legal spouse or parent of a minor child.**

### Service Combinations

Family Personal Care is an all-inclusive 24-hour service. Therefore, respite care service and Emergency Response System (ERS) along with Family Personal Care is acceptable only as described under the following circumstances:

1. The individual meets the eligibility criteria for Respite Care Services or when the qualified family member provides less than 24-hour per day care on a routine basis, and the individual can be left alone safely for brief periods of time, respite care is appropriate only when the qualified family member will be gone for an extended period of time, for example, to attend a wedding.

If individual cannot be safely left alone or supervision is an authorized task on the MRW respite care must be authorized so the qualified family member can take necessary breaks away from their caregiving responsibilities.

- Respite care must be authorized because FPC providers cannot delegate their care to another individual if an individual cannot be safely left alone.
- If informal respite is in place and of benefit to the individual, the case manager must document that formal respite care was offered and declined.

2. Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FPC provider's short term absence. ERS is not acceptable for individuals who require supervision for cognitive or health related reasons. [Contact the HCBS Program](#)

~~Administrator in writing to obtain approval for the combination of FPC and ERS service.~~

**Homemaker Service 525-05-30-35  
(Revised 04/01/22 ML #3685)**Purpose

The purpose of Homemaker Service is to complete intermittent or occasional environmental tasks that an eligible individual is not able to complete him or herself in order to maintain that individual's home.

Service Eligibility Criteria for

The individual receiving homemaker service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. Needs assistance with environmental tasks that are within the scope of this service.
3. For live-in providers the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service activity benefits the individual.

The department may pay a provider for homemaker tasks that would otherwise be considered the individual's share of the responsibility to complete the task. An example of this would be authorizing housekeeping for the individual's personal private space OR their shared responsibility of cleaning the common living space.

4. For an individual who lives with an able-bodied adult, ~~prior approval for Homemaker Service must be obtained from the HCBS Program Administrator. the department may pay a provider for homemaker activities involving the individual's personal private space and if the individual is living with an adult, the individual's share of the common living space.~~

- ~~The department may pay a provider for homemaker activities involving the individual's personal private space and if the individual is living with an adult, the individual's share of the common living space.~~

5. The need for environmental tasks/activities is intermittent or occasional.

6. Occasionally the provision of Homemaker Service tasks/activities may impact other family members. When this occurs, it must be considered insignificant or must be inseparable from tasks/activities provided to the individual (e.g. cooking, cleaning).

7. The funding cap applies to a household and may not be exceeded regardless of the number of eligible individuals residing in the home.

**EXAMPLE:** If a husband and wife both qualify for homemaker services, the max funding cap must be shared by both individuals. The total number of units should be divided between the individuals in the home and included on each individual care plan, but the cap cannot be exceeded.

#### Service Tasks/Activities

1. Housework
2. Meal Preparation
3. Laundry
4. Shopping
  - a. Transportation or escorting of the individual are unallowable
5. Communication
6. Managing Money

#### Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- Workplace
- Other community service settings

#### Services Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are defined on the Authorization to Provide Services.
2. When an individual receives assistance with laundry, shopping, housekeeping, under Medicaid State Plan Personal Care (MSP-PC) in excess of the funding cap allowed for homemaker services under SPED, EXSPED, or HCBS Wavier, additional tasks of Meal Prep, Communication or Managing Money may not be authorized under Homemaker Services.
3. If an individual is receiving MSP-Personal Care assistance for meal prep, communication, and money management, these tasks are not allowable homemaker tasks unless approval is obtained from a HCBS Program Administrator.
4. If an individual is receiving MSP-Personal Care, the tasks of laundry, shopping, and housekeeping cannot exceed 30% of the entire care plan. When MSP-PC units are authorized, homemaker tasks must be authorized under this funding source (MSP-PC) unless:
  - MSP-PC Level C is authorized; or
  - the total cost of the maximum number of units that are able to be moved from SPED/Ex-SPED and authorized under MSP-PC is less than \$150. (When calculating whether this cost is under \$150, first determine how many homemaker units you are able to move to MSP-PC. Then, take that number of units

and multiply it by the current homemaker rate. If that total is less than \$150, you do not need to move the units from SPED/Ex-SPED over to MSP-PC.)

- If a rural differential (RD) rate is authorized, the RD rate must be used to calculate the laundry, shopping, housekeeping total cost.

5. Homemaker is authorized under Medicaid Waiver. In that case, all HMK tasks may be authorized under MSP-PC Levels A and B or Medicaid Waiver since both (MSP-PC and Medicaid Waiver) are Medicaid-funded programs.

### Providers

Homemaker Service may be provided by the following individual QSP's or employees of a QSP agency (**checked if allowable**):

- Guardian
- Legally Responsible Person - Legal spouse or parent of a minor child.
- Relative (who does not live with the individual) within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2.02.**

## **Specialized Equipment and Supplies 525-05-30-60 (Revised 04/01/22 ML#3685)**

### Purpose

Specialized Equipment and Supplies Service includes the purchase of equipment and supplies that will facilitate or promote a recipient's independent functioning within his or her home or family member's home if the recipient resides in the home. The service is not physician driven nor is the allowable equipment and supplies authorized for purchase under this service chapter to primarily serve medical needs, although, the products may indirectly assist with medical needs.

Specialized equipment is supplies, safety devices, or assistive technology that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Coverage may include the cost of set up, maintenance, and upkeep of equipment, and may also include the cost of training the participant or caregivers in the operation and/or maintenance of the equipment.

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

Assistive technology includes:

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

#### Service Eligibility, Criteria for

The individual receiving Specialized Equipment and Supplies Services must meet the following criteria:

1. Must be eligible for the programs of Medicaid Waiver for Home and Community Services.
2. The basis of need for the equipment is established through the assessment process and must include an adaptive assessment completed by a professional with expertise in the equipment requested, (e.g. PT/OT, Speech and Hearing and Assistive Technology Professionals, (ATP), etc.). Prior approval is required for the purchase of specialized equipment or supplies.
3. The equipment purchased is of significant benefit to the applicant/recipient in the performance of personal cares and/or household tasks in the home.
4. The recipient does not already have access to a product that serves essentially the same purpose.
5. The need for the equipment is expected to extend indefinitely.
6. The individual is motivated to use the equipment.
7. A written bid must be obtained for any specialized equipment and/or supplies funded under this service chapter. If the equipment or supplies are considered durable medical equipment (DME), the bid must include healthcare common procedure coding system (HCPCS) codes.
8. The equipment is a non-covered item under the Title XIX State Medicaid Plan or unavailable through other funding sources. A list of ND Medicaid DME covered items may be found at

<http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html>.

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

### Limits

The costs are limited to what is budgeted per person for Specialized Equipment and Supplies in the federally approved in the Medicaid Waiver(s).

Items reimbursed with waiver funds are only for medical equipment and supplies not covered under the State Plan; and exclude those items that are not of direct medical or remedial benefit to the participant.

All items shall meet applicable standards of manufacture and design.

### Specialized Equipment and Supplies, Scope of

The products covered under this Service Chapter are ADL/IADL related products that are not covered under the Title XIX Medicaid State Plan. Examples of such specialized equipment and supplies may include but are not limited to the following:

1. Communication Board
2. Remote control device to safely operate electronic appliances such as microwave, garbage disposal, blender, toaster, television, etc.
3. Special designed wheelchair lap tray
4. Specialized positioning devices(s)
5. Safety devices and equipment
6. Generic technical devices (tablets, computers, etc) are allowed when they are needed for the functionality of other assistive technology such as smart home devices.

### Specialized Equipment and Supplies, Delivery Of

When it has been determined that a specific item(s) (applicable to this service chapter) will be of benefit to the applicant/recipient, the following procedure is followed:

1. The HCBS Case Manager will contact a supplier of the specialized equipment and/or supplies who are enrolled as a Qualified Service Provider or may be willing to enroll as a Qualified Service Provider. The purpose of the contact is to authorize purchase of the approved item and to verify the cost.
2. The supplier will ship/mail the item only upon receipt of the Authorization to Provide Medicaid Waiver Service preauth or preliminary authorization, SFN 410. The Qualified Service Provider will

request payment from the Department of Human Services using the QSP payment system.

3. The supplier is responsible to arrange for or provide any instruction the recipient may need to use the specialized equipment.
4. One month following delivery, the HCBS Case Manager is to contact the recipient to monitor the effectiveness of the specialized equipment. The results of this monitoring contact are documented in the case file. It is at this point that Specialized Equipment and Supplies Service should be deleted from the Person Centered Plan of Care if no further need exists for the reimbursable items of this service chapter.

### **Supervision 525-05-30-63 (Revised 04/01/2022 ML#3685)**

#### Purpose

Supervision may be provided to assist eligible individuals remain in their home and community.

Up to 24 hours of supervision may be provided to individuals who, because of their disability, need monitoring to assure their continued health and safety. Recipients must have a need for supervision as described in this chapter.

#### Service Description

An individual could be considered to have a need for supervision if, because of their impairment, they have delusions, hallucinations, severe depression, emotionally labile (severe mood swings) and or other behaviors like screaming, hitting, kicking, biting, wandering, hyperactivity, aggression, inappropriateness, elopement (running away), or frequent falls that may require human intervention to safeguard the individual from harm. (The list of behaviors/needs is not an all-inclusive list).

- Payment for supervision cannot be claimed while ADL & IADL supports or homemaker task are being provided. Those tasks would be billed under personal care or homemaker.

#### Service Eligibility, Criteria for

The individual receiving supervision will meet the following criteria:

1. Must be eligible for the HCBS Medicaid waiver program;
2. Be at least age 18;
3. The care needs of the individual must fall within the scope of supervision as described in this service chapter.

4. If an individual requires supervision 24 hours per day, the case manager must justify in the individual narrative/case note why the individual needs the support of awake staff to assure health and safety needs are met at night. Providers, who provide supervision at night while the individual is sleeping must stay awake while providing supervision.
5. ~~Prior approval from a HCBS Program Administrator is required before this service may be authorized.~~

### Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- Workplace
- Other community service settings

### Service Tasks/Activities

Allowable supervision tasks include: Having the knowledge of, and account for, the activity and whereabouts of the individual at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. During the time that the provider is supervising the individual and is not actively providing personal care or homemaker tasks etc., they may play games, visit, read, and participate in activities with the individual. If the individual is physically able, they may also participate in activities on or around the individual's home such as gardening, or going for short walks etc.

The following tasks are not considered allowable tasks under this chapter because they would be provided under personal care or homemaker: Bathing, dress/undress, eye care, feeding/eating, hair/care/shaving, incontinence, mobility, nail (finger) care, skin care, teeth/mouth care, toileting, transferring/turning/ positioning. The global endorsements of exercise, hooyer lift/mechanized bath chair, indwelling catheter, medical gases, prosthetic, orthotics, suppository, bowel program, ted socks, Temp/BP/pulse/respiration rate. The client specific endorsements of apnea monitor, jobst stockings, ostomy care, postural /bronchial drainage, ric bed care. Communication, housework, laundry, meal preparation money management, and shopping are not allowable service tasks under this service. Individuals who live alone or with a non-relative are still eligible for home maker services. Medication assistance is not an allowable task under this service.

### Supervision outside of the individual's home

Payment cannot be made for time performing authorized supervision tasks outside of the individual's home/grounds.

1. Exception: When the individual is required to seek essential services i.e. medical care etc. outside of North Dakota, contact the HCBS Program Administrator for approval.
  - o If an individual receiving supervision needs transportation to an essential community service, non-medical transportation with escort may be authorized.

#### Cognitively Impaired Individuals, Services to

For cognitively impaired individuals who are receiving less than 24 hours of personal care with supervision, the care plan must identify how the daily care needs are being met (including supervision) during the time no provider is in the home. During those periods of time when personal care with supervision service is not being provided, cooperative and coordinated efforts of meeting the needs of the individual by the family, other informal providers, must be identified.

#### Service Activities, Authorized and Limits

1. Under Supervision, Community Integration, Social Appropriateness, and Transportation are tasks which cannot be authorized under this chapter. If an individual needs these tasks they must be authorized under Transitional Living, Residential Habilitation, or Community Support Services.
2. Supervision can be combined with adult day care, chore, community transition services, environmental modification, extended personal care, homemaker, home delivered meals, non-medical transportation, non-medical transportation w/escort, personal care, transitional living, specialized equipment, and supported employment.
3. Supervision cannot be combined with, respite care, emergency response system, adult foster care, residential services, and family personal care.
4. For unusual or unique circumstances, approval from the HCBS Program Administrator must be obtained.

#### Authorizing Service

1. The service tasks/activities within the scope of this service chapter must be identified on the Authorization to Provide Service.
2. The amount of units allocated for supervision of the individual is determined by subtracting the amount of time the individual is receiving informal supports and authorized services i.e. personal care, homemaker etc. from a 24 hour period.

**Example:** If an individual requiring 24/7 supports receives 4 hours of informal supports and 6 hours per day of personal care, they would be eligible for 14 hours of supervision.

3. The supervision provider may also be the personal care, homemaker provider etc. However, there must be more than one QSP identified on the care plan as it is not reasonable to allow one provider to be responsible for 24 hours of care per day.

### Standards for Providers

Supervision providers must meet the same standards as respite providers that includes having the global endorsement for cognitive/supervision.

### Providers

Supervision may be provided by the following individual QSP's or employees of a QSP agency (**checked if allowable**):

- Guardian
- Legally Responsible Person - Legal spouse or parent of a minor child.
- ✓ **Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.**

## **Standards for Qualified Service Provider(s) 525-05-45 (Revised 04/01/22 ML #3685)**

### Provider Enrollment

#### Purpose

The purpose of Provider Enrollment is to ensure that Qualified Service Providers meet the standards and qualifications set by the Department of Human Services and Federal Regulations for providing services to eligible Home and Community Based Service recipients.

#### Legal Authority

Code of Federal Regulations (CFR) Title 42, Chapter IV, Subchapter C, Part 455, Subpart E

Century Code 50-11-02.4

Century Code 50-11-06.8  
Century Code 50-11-06.9  
N.D. Admin. Code 75-03-23-07  
N.D. Admin. Code 75-03-23-08  
N.D. Admin. Code 75-03-23-10  
N.D. Admin. Code 75-03-21-08

### Standards for Qualified Service Providers

1. Must be 18 years of age.
2. Must meet the standards of CFR Part 455-Program Integrity Medicaid.
3. Must meet the provider standards and agreements according to the N.D. Admin. Code and CFR.
4. Per ND Admin. Code 75-03-23-08(1)(n)(2)(o)(p), QSPs must have been actively billing in the past 12 months or have valid reason for inactivity to renew or they may be closed for inactivity.
5. No outstanding debts can be owed to the Department of Human Service.
6. Documentation of Competency, registered nurse licensure, licensed practical nurse, certified nurse assistant certification, physician, physician assistant, nurse practitioner, physical therapist license, or occupational therapist must be current and up to date. (FHC does not require a documentation of competency)
7. Family home care and family personal care providers must have an eligible ~~client~~ individual identified by the HCBS Case Manager before enrollment will be completed.
8. Bureau of Criminal Investigation background checks and fingerprint screening must be done for Adult Foster Care (AFC) and Respite providers in an AFC home per Admin. Code 75-03-21-08(1)(h) and Century Code 50-11-02.4, 50-11-06.8, and 50-11-06.9.

For additional information about provider standards refer to the current QUALIFIED SERVICE PROVIDER (QSP) HANDBOOKS. For a copy of one or both QSP Handbooks, contact the HCBS Program Administration.

### Standards for Qualified Service Providers for Environmental Modification

- Environmental Modification Service may only be provided by a contractor approved by the Department of Human Services as a Qualified Service Provider. Standards for Qualified Service Providers of Environmental Modification Service are as follows:
  - Building contractors must have a current North Dakota Contractor's license, carry liability insurance, be bonded,

and maintain good standing with Workforce Safety Insurance. Show verification of an appropriate building permit.

- Electricians must be licensed by the North Dakota State Electrical Board, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance.
- Plumbers must be licensed by the North Dakota State Plumbing Board, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance.
- All licensed and unlicensed contractors must provide a copy of their registration with the Secretary of State; provide a copy of their license, proof of liability insurance/bonding, and proof of enrollment and good standing with Workforce Safety and Insurance. These documents must be submitted with the request to be a Qualified Service Provider (QSP).
- The North Dakota Century Code (NDCC 43-07-02) allows for a handyman to complete jobs not exceeding \$4000 without a contractor's license. If the handyman does not have a contractor's license they must provide a letter of reference showing they meet the qualifications to do minor installs and modifications to the home. The handyman would be allowed to provide installs and modifications to the home not exceeding \$4000 in time and materials. A licensed contractor would qualify as a QSP with their contractor's license and is not limited to the \$4000 threshold.
  - An unlicensed handyman/contractor/tradesman may meet the QSP criteria for Environmental Modification with the following requirements:
    - verification of good standing with Workforce Safety and Insurance.
    - Provide a professional reference relevant to their ability to complete the necessary work.

#### Standards for Home Delivered Meal Providers

- Enrolled as an individual or agency Qualified Service Provider;
- Licensed as a food establishment pursuant to [NDCC 23-09](#), Hospital, nursing facility, basic care facility; or contracted with Aging Services Division as an OAA Nutrition Provider;

- Meet all applicable federal, state, and local laws and regulations regarding the safe and sanitary handling of food, equipment, supplies and materials used in storage, preparation, and delivery of meals to eligible recipients pursuant to the ND Requirements for Food and Beverage Establishments ([NDAC 33-33-04](#)).
- Providers licensed as a Hospital must also meet standards pursuant to [NDCC 23-16](#), [NDAC 33-07-01.1](#), & [NDAC 33-07-02.1](#)
- Providers licensed as a nursing facility must also meet standards pursuant to NDCC 23-16 & [NDAC 33-07-03.2](#) & [NDAC 33-07-04.2](#)
- Providers licensed as basic care must also meet standards pursuant to [NDCC 23-09.3](#) & [NDAC 33-03-24.1](#)

#### Provider Enrollment Limitations

1. All verification screenings required by the federal and state laws, rules, or regulations must be complete before enrollment can be finalized.
2. The enrollment effective date cannot be prior to the required verification screening date.
3. Effective enrollment date for services of Family Home Care or Family Personal Care may not be prior to ~~individual client~~/member's signature on care plan.
4. A Monthly Rate Worksheet SFN 1012 must be sent to the QSP provider enrollment Program Administrator before final approval of QSP for Family Home Care or Family Personal Care will be granted.
5. If enrollment is not complete by the end of the 30 day notice period, the QSP status will be stopped and a new start date will be given if/when a complete application is received and approved.
6. Any break in licensure or documentation of competency dates will result in a stop and new start date.
7. A break in renewal status greater than 30 days from the QSP closed date will result in a stop and a new start date and a complete application will be required. (This is due to the monthly renewal verification checks not being completed as required)

#### Provider Reimbursement Limitations

1. QSP's will not be paid with public funds until the enrollment requirements are fulfilled, and a current authorization is received from the Case Manager.
2. QSP's will not be eligible for payment during the period when their QSP enrollment status lapsed.
3. QSP's are not eligible for payment earlier than the effective date on the authorization to provide services issued by the case manager, therefore the enrollment date **may not** be the date a provider can start billing.

### Enrollment Process for New Applicants

- All forms must be completed correctly and the required verification checks by the HCBS Program Administrator must be complete before an enrollment start and end date will be given (dates cannot be retroactive).
  - The following provider verifications must be completed by the HCBS Program Administrator according to the CFR and state regulations:
    - Verification of current competency, certification, or licensure and good standing in state
    - List of Excluded Individuals and Entities (LEIE)(OIG)
    - Excluded Parties List System (SAMS) Previously (EPLS)
    - National Sex Offender Site
    - ND Sex Offender Site
    - Child Abuse and Neglect Background Inquiry
    - Check Termination and Denial list
    - Check Certified Nurse Assistance Abuse list
    - Health Market Science (HMS) or Accurant check which includes the following:
      - OIG (Office of Inspector General)
        - State Medicaid Exclusion
        - Social Security Administration Death Master File
        - National Plan and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
        - DEA (Drug Enforcement Administration)
        - Addresses
4. QSP will be issued an "enrollment end date" no longer than 24 months from the date of enrollment.
5. Enrollment end date may be up to 23 months from original competency date to allow sufficient time for renewal.

### Enrollment Process for Family Home Care and Family Personal Care

1. All forms must be completed correctly and the required verification checks by the HCBS Program Administrator must be complete before an enrollment start and end date will be given.
2. The following provider verifications must be completed by the HCBS Program Administrator according to the CFR and state regulations:
  - Verification of current competency, certification, or licensure and good standing in state
  - List of Excluded Individuals and Entities (LEIE)(OIG)
  - Excluded Parties List System (SAMS) Previously (EPLS)
  - National Sex Offender Site

- ND Sex Offender Site
  - Child Abuse and Neglect Background Inquiry
  - Check Termination and Denial list
  - Check Certified Nurse Assistance Abuse list
  - Health Market Science (HMS) or Accurint check which includes the following:
    - OIG (Office of Inspector General)
    - State Medicaid Exclusion
    - Social Security Administration Death Master File
    - National Plans and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
    - DEA (Drug Enforcement Administration)
    - Addresses
3. Family Home Care does not require documentation of competency.
4. Family Personal Care requires that a valid proof of competency be sent with the application.
5. Effective enrollment date of QSP enrollment for the services of Family Home Care or Family Personal Care may not be prior to the date of the individual client/member's signature on the care plan.
6. A monthly rate worksheet must be sent to the QSP provider enrollment Program Administrator before final approval of QSP for Family Home Care or Family Personal Care will be granted.
7. A start date will be determined by reviewing:
- The completed application;
  - Provider screening verification date;
  - Individual client approval date for service;
  - Individual client /member signature on care plan and;
  - Monthly Rate Worksheet.
8. QSP will be issued an "enrollment end date" no longer than 24 months from enrollment.
9. Enrollment end date may be up to 23 months from original competency date for family personal care or the date of signature on the Medicaid Agreement for family home care, to allow sufficient time for renewal.