

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 and old language is in red and has been struck through.

Par. 2. **Effective Date** – March 1, 2024

Standards for Qualified Service Provider(s) 525-05-45
(Revised ~~04/01/23~~ 03/01/2024 ML #~~3723~~3846)

NOTE: The full section of 525-05-45 has been redacted, and split into subsections. 525-05-45 has now become the main Chapter.

Provider Enrollment

Purpose

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

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Legal Authority

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

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~~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~~

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Standards for Qualified Service Providers

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- ~~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.~~
- ~~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 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.~~

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~~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 QSP Provider Enrollment.~~

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~~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.~~

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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~~

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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/member's signature on care plan.~~
- ~~4. A Monthly Rate Worksheet SFN 1012 must be sent to QSP Provider Enrollment 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

- ~~1. All forms must be completed correctly and the required verification checks by QSP Provider Enrollment must be complete before an enrollment start and end date will be given (dates cannot be retroactive).~~
- ~~2. The following provider verifications must be completed QSP Provider Enrollment 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~~
 - ~~○ Check Termination and Denial list~~
 - ~~○ Check Certified Nurse Assistance Abuse list~~
 - ~~○ Health Market Science (HMS) or Accurant check which includes the following:~~

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- ~~○—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.—A QSP will be issued an “enrollment end date” no longer than 60 months from the date of enrollment.~~
- ~~4.—A QSP is required to revalidate their QSP enrollment by providing evidence of competency at least every 60 months for an agency, and at least every 30 months for an individual enrolled as a QSP.~~

~~Enrollment Process for Family Home Care (FHC) and Family Personal Care (FPC)~~

- ~~1.—All forms must be completed correctly and the required verification checks by QSP Provider Enrollment must be complete before an enrollment start and end date will be given.~~
- ~~2.—The following provider verifications must be completed by QSP Provider Enrollment 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~~
 - ~~○—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 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/member's signature on the care plan.~~
- ~~6. A monthly rate worksheet must be sent to the QSP Provider Enrollment 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 approval date for service;~~
 - ~~○ Individual/member signature on care plan and;~~
 - ~~○ Monthly Rate Worksheet.~~~~
- ~~8. QSP for FHC will be issued an "enrollment end date" no longer than 60 months from enrollment.~~
- ~~9. Enrollment end date may be up to 60 months from original competency date for family personal care or the date of signature on the Medicaid Agreement for family home care.~~
- ~~10. A QSP for FHC is required to revalidate qualified service provider enrollment every sixty months for an individual enrolled as a qualified service provider providing family home care services under the Service Payments for the Elderly and Disabled (SPED) program and Expanded Service Payments for Elderly and Disabled (EXSPED).~~

Enrollment Process for Renewals

- ~~1. All forms must be completed correctly, and the required verification checks by QSP Provider Enrollment must be complete before renewal of QSP status can be approved.~~
- ~~2. The following provider verifications must be completed by QSP Provider Enrollment according to the CFR and state regulations:
 - ~~○ Verification of current competency, certification, or licensure and good standing in state
 - ~~○ Evidence of competency is required at least every sixty (60) months for an agency enrolled as a qualified service provider or at least thirty (30) months for an individual enrolled as a qualified service provider.~~~~
 - ~~○ List of Excluded Individuals and Entities (LEIE)(OIG)~~
 - ~~○ Excluded Parties List System (SAMS) Previously (EPLS)~~
 - ~~○ National Sex Offender Site~~
 - ~~○ ND Sex Offender Site~~
 - ~~○ 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~~

- ~~3. QSP is given an "enrollment end date" no longer than 60 months from enrollment.~~
- ~~4. Enrollment end date may be up to 59 months from original competency date to allow sufficient time for renewal.~~
- ~~5. Six to eight weeks prior to the end date, the QSP will be sent a renewal application.~~
- ~~6. If renewal is not received by the renewal end date, the QSP and the HCBS Case Manager and/or the DD Program Manager will be sent a written notification of a 30 day stop notice period, allowing the provider 30 extra days to renew.~~
- ~~7. If renewal is not received and processed during the 30 day stop notice period, the QSP must be taken off the care plan.~~
- ~~8. QSP wishing to continue to provide care must have a complete application submitted and approved before. (There will be no retroactive dates after the 30 day notice).~~

Exceptions

- ~~1. Requests for exceptions will be reviewed and considered but will not be granted unless the provider meets all the competency requirements and all required screenings and verifications have been completed.~~
- ~~2. Prior approval is required by the HCBS Program Administrator.~~

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Provider Addresses

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~~QSP mail returned twice, with no forwarding address, will result in a closure of QSP status. The HCBS Case Manager or DD Program Manager will be notified of closure date.~~

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~~If the QSP provides a valid address and meets all provider enrollment requirements, the QSP status will be opened.~~

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~~If the QSP mail is returned notifying the department that the QSP has moved to a state that does not border North Dakota, the QSP will be closed and given a stop notice.~~

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30 Day Stop Notice

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~~A 30-day stop notice is the period of time when a written notification is sent to the QSP and case manager, allowing the QSP time to renew enrollment status, without losing eligibility for reimbursement from the state. During this period a valid Documentation of Competency SFN 750, licensure, or certification and all completed renewal forms must be received by the Department and all required provider verifications must be completed.~~

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~~**NOTE: The QSP must meet all requirements and is still competent during the 30-day stop notice period. The notice is sent to assure QSPs understand that they have 30 days to complete the application or they will no longer be eligible for reimbursement.**~~

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~~**If the application is not complete after the 30-day stop notice period has ended, the case manager must remove the QSP from the care plan.**~~

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Stop and Start dates

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~~If the 30-day stop notice date has passed, and the QSP has not submitted an application, or their submitted application is not complete, QSP status will be closed. If the QSP submits a complete application or finalizes a previously submitted application they will receive a new QSP enrollment start date. The QSP will not be eligible for reimbursement between the stop and new start date.~~

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Closure for Inactivity

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~~QSPs with no billing activity within the last 12-15 months will receive a 30-day stop notice. The notice will allow the QSP time to notify the Department of the reason for inactivity.~~

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~~If a valid reason for inactivity is not received within the 30-day stop notice, the QSP status will be stopped.~~

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15-minute unit rates

~~Providers must deliver at least 8 minutes of service before they can bill for the first 15-minute unit. Providers should not bill for services performed for less than 8 minutes. This applies to all procedure codes billed using a 15-minute unit rate.~~

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~~The amount of time required to bill for a larger number of units is as follows:~~

~~2-units: at least 23 minutes — 6-units: at least 83 minutes~~

~~3 units: at least 38 minutes — 7 units: at least 98 minutes
4 units: at least 53 minutes — 8 units: at least 113 minutes
5 units: at least 68 minutes~~

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~~The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).~~

Qualified Service Provider Enrollment 525-05-45-10 (NEW 03/01/24 ML #3846)

Purpose

The purpose of Provider Enrollment is to ensure that Qualified Service Providers (QSPs) meet the standards and qualifications set by the Department of Health and Human Services (HHS) 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 revalidate or they may be closed for inactivity.
5. No outstanding debts can be owed to the Department.
 - o If an outstanding debt is owed to the Department, payment arrangements may be considered as an allowance and condition of enrollment approval.
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 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.
9. QSPs must have an email account to create an account in the QSP Portal and receive correspondence from the Department.
 - o Paperless communication is the preferred method of communication. However, individuals who need accommodation can request information to be sent in a different format. Contact the QSP Hub to request accommodation.

For additional information about provider standards refer to the current QUALIFIED SERVICE PROVIDER (QSP) HANDBOOKS, available on the QSP website: <https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service>.

Standards for Qualified Service Providers (QSP) for Environmental Modification

- Environmental Modification Service may only be provided by a contractor approved by the Department of Health and Human Services as a QSP. Standards for QSPs 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 QSP enrollment effective date cannot be prior to the provider NPI enumeration date, if applicable.
3. The effective date for QSP enrollment for services of Family Home Care (FHC) or Family Personal Care (FPC) may not be prior to individual/member's signature on care plan.

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.
4. QSPs are required to provide a direct deposit account upon initial enrollment and maintain a current checking or savings account for direct deposit at all times. If the QSP does not maintain a current

account or update HHS when updated information is requested, the QSPs enrollment status will be closed.

Enrollment Process for New Applicants

1. A complete and accurate application including all forms and required verification checks by QSP Enrollment must be complete before an enrollment approval will be given (enrollment dates cannot be retroactive).
2. The following provider verifications must be completed by QSP Enrollment 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)
 - National Sex Offender Site
 - ND Sex Offender Site
 - Check Termination and Denial list
 - Check Certified Nurse Assistance Abuse list
 - Health Market Science (HMS) or equivalent screening 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. A QSP will be issued an "enrollment expiration date" no longer than 60 months from the date of enrollment approval.

Enrollment Process for Family Home Care (FHC) and Family Personal Care (FPC)

1. The case manager must initiate the application for the FHC or FPC provider in the QSP Enrollment portal.
2. The QSP applicant submits a complete and accurate application, including uploading the required documentation in the QSP enrollment portal.
3. QSP Enrollment must complete required screening and verification checks 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)
 - National Sex Offender Site
 - ND Sex Offender Site
 - 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 (NPPE) or NPI (National Provider Identifier) Registry
 - DEA (Drug Enforcement Administration)
 - Addresses
4. Family Home Care does not require an SFN 750- Documentation of Competency.
 5. Family Personal Care requires a valid proof of competency with the application.
 - Valid proof of competency includes a SFN 750 or current CNA, RN or LPN verification.
 6. The effective enrollment date for the services of Family Home Care or Family Personal Care may not be prior to the date of the individual/member's signature on the care plan.
 7. The HCBS case manager verifies the QSP applicant will be providing FHC or FPC with QSP Enrollment before final approval will be granted.
 8. A start date will be determined by reviewing:
 - The completed application;
 - Provider screening verification date;
 - Individual approval date for service;
 9. The QSP will be issued an "enrollment expiration date" no longer than 60 months from enrollment approval date.
 10. Revalidation of QSP enrollment is required every sixty months for an individual enrolled as a FHC or FPC QSP.
 11. Revalidation of QSP enrollment is required every sixty months for an individual enrolled as a FHC or FPC QSP.

HCBS Case Management Guidance for Family Home Care and Family Personal Care QSP Application

Step 1: Ask the potential QSP what email they want to use to set up their ND Portal account.

If they don't have an email, they should use one of the free email sites (yahoo, google etc.) to set one up. They need to keep track of the email and check it frequently. If they want to use someone else's email for this, they must have written permission from the eligible individual.

If they don't know how to set up an email, they can contact the QSP Hub for assistance. (Please note that they will likely need to schedule a time and help may not be available on demand due to the volume of TA being requested.)

Step 2: The potential QSP should follow the attached user guide for family home care or family personal care and log into their current ND portal or set up a new account in the ND portal. If they need help with this step, they can call the QSP Hub and set up a time.

Step 3: The potential QSP should let you know when they have logged into their ND portal account.

Step 4: The HCBS Case Manager should follow the attached user guide and log into the QSP portal and initiate a FHC or FPC application.

Step 5: The HCBS Case Manager should let the potential QSP know they can log into the QSP portal (using the correct email) and fill out the FHC or FPC application. They will be notified via email when the application is approved. You will be able to see the application and each stage of the process for each application you initiate.

Enrollment Revalidation

A notice will be sent through the QSP Enrollment Portal when QSP revalidation is due.

Note: Paperless communication is the preferred method of communication. However, individuals who need accommodation can request information to be sent in a different format. Contact the QSP Hub to request accommodation.

1. A complete and accurate application including all forms and required verification checks by QSP Enrollment must be complete before revalidation of QSP status can be approved.
2. The following provider verifications must be completed by QSP Enrollment according to the CFR and state regulations:
 - Verification of current competency, certification, or licensure and good standing in state
 - Evidence of competency is required at least every sixty (60) months for an agency enrolled as a qualified service provider or at least thirty (30) months for an individual enrolled as a qualified service provider.
 - List of Excluded Individuals and Entities (LEIE)(OIG)
 - Excluded Parties List System (SAMS)
 - National Sex Offender Site
 - ND Sex Offender Site
 - 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. QSP is given an "enrollment expiration date" no longer than 60 months from enrollment approval date.
4. Individual QSPs will be given a 30-day notice in the Enrollment Portal to revalidate their enrollment.
5. Agency QSPs will be given a 90-day notice in the Enrollment Portal to revalidate their enrollment.
6. If revalidation is not completed by the expiration date, the QSP is given a stop date and sent written notification of 30 extra days to revalidate. A new start date will be given if/when a complete application is received and approved.
7. HCBS Case Manager and/or the DD Program Manager will be sent a written notification of a 30 day stop notice period, allowing the provider 30 extra days to revalidate. If revalidation is not received and

processed during the 30 day stop notice period, the QSP must be taken off the care plan.

8. QSP wishing to continue to provide care must have a complete application submitted and approved before the final stop date issued in the 30-day notice. (There will be no retroactive dates after the 30-day notice).

Exceptions

1. Requests for exceptions will be reviewed and considered but will not be granted unless the provider meets all the competency requirements and all required screenings and verifications have been completed.
2. Prior approval is required by the QSP or HCBS Program Administrator.

Competency Revalidations

1. Individual QSP competency is valid for the length of their license if verified by a CNA, LPN or RN or 30 months if verified by an SFN 750, Documentation of Competency. The Individual QSP is required to revalidate their competency by re-establishing proof of competency at least every 30 months or at the expiration of their certificate or licensure.
2. Agency QSP employee competency is valid for the length of their license if verified by CNA, LPN or RN or 60 months if verified by an SFN 749 -Documentation of Competency – Agency QSP Employee. The Agency employee is required to revalidate their competency by re-establishing proof of competency at least every 60 months or at the expiration of their certificate or licensure.
3. QSPs enrolled for a service that is dependent upon a license must submit proof of license renewal to maintain enrollment for the specific service.
4. A notice will be sent through the QSP Enrollment Portal when an updated competency or license renewal/revalidation is due. The QSP must provide updated information as requested or enrollment will be closed.

Provider Addresses

QSP mail returned twice, with no forwarding address, will result in a closure of QSP status. The HCBS Case Manager or DD Program Manager will be notified of closure date.

If the QSP provides a valid address and meets all provider enrollment requirements, the QSP status will be opened; however, there may be a gap in enrollment approval dates.

If the QSP mail is returned notifying the department that the QSP has moved to a state that does not border North Dakota, the QSP will be closed and given a stop notice.

Closure for Inactivity

QSPs with no billing activity within the last 12-15 months will receive a non-billing notice. The notice will allow the QSP time to provide the Department of the reason for inactivity.

If a valid reason for inactivity is not received within 30 days, the QSP status will be stopped.

15 minute unit rates

Providers must deliver at least 8 minutes of service before they can bill for the first 15 minute unit. Providers should not bill for services performed for less than 8 minutes. This applies to all procedure codes billed using a 15 minute unit rate.

The amount of time required to bill for a larger number of units is as follows:

2 units: at least 23 minutes 6 units: at least 83 minutes

3 units: at least 38 minutes 7 units: at least 98 minutes

4 units: at least 53 minutes 8 units: at least 113 minutes

5 units: at least 68 minutes

The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).

Daily Rate Service Rates

Add Providers must provide one hour of service to bill for daily rate services.

Electronic Visit Verification Requirements

Electronic Visit Verification (EVV) uses a mobile device application on a phone, tablet, or laptop that records the beginning and ending time of services provided to individuals by providers. Data may also be captured using a fixed object device (FOD) issued to the provider by HHS. This electronically verifies the service was provided at a particular location where the service is authorized, as required by the law. EVV is a federal requirement from the 21st Century Cures Act and became effective January 1, 2021, it is used for billing and payment of services you provide as a QSP.

All QSPs are required to participate in an EVV system if they enroll in at least one of the services subject to EVV. QSPs must have access to a FOB, phone, tablet, or laptop to utilize this system. This is necessary to check in and out when providing services, receiving service authorizations, and submitting claims electronically. Not all services require EVV to bill for services provided.

EVV programming under Therap includes the option to enter and store the documentation that is required for QSP services. This programming is called ISP Data and meets the standard for QSP documentation. ISP Data is only available to QSPs using Therap for EVV.

Referrals for Qualified Service Providers 525-05-45-20 (NEW 3/1/24 ML #3846)

QSP's may receive referrals from HCBS Case Managers, DD Program Managers (DDPM), Community Support Coordinators (CSC) or QSP Navigators.

Aging Services Qualified Service Provider (QSP) Navigators connect Individual(s) QSP/Agencies with individuals eligible for Home and

Community-Based Services (HCBS) and/or working with Community Service Coordinators (CSCs) through the following process:

1. The HCBS case managers and CSC send referrals for individuals requesting assistance locating a QSP to the QSP Navigator group email by completing and emailing an SFN 1268 to qspnavigator@nd.gov.
 - If the individual has a provider in mind or know one that will provide the services, the HCBS case manager and CSC a referral is not required to send to the QSP Navigator.
2. The QSP navigator will review the referral for completeness, paying particular attention to the "Start Date."
3. The QSP Navigator will reach out to the individual/agency QSPs via the preferred method of communication.
4. If there is no response back from the QSP individual(s)/agency(ices) after 24 business hours, the QSP Navigator will initiate follow-up calls and email.
5. When a QSP individual(s)/agency has been located for HCBS or CSC the QSP Navigator will send a message back to the HCBS case manager and the QSP individual/agency (on the same email) with all the information:
 - QSP individual(s)/agency name and contact information.
 - What services the QSP individual(s)/agency can provide.
 - What days the QSP individual(s)/agency are available.
 - Along with attaching the SFN 1268 referral that was submitted by the HCBS case manager, so the QSP individual/agency has a copy.
6. The HCBS case manager and/or CSC must follow up with the QSP individual/agency to answer any additional questions they have regarding the SFN 1268 referral.

QSP's Referral Acceptance

Accepting referrals – requires two confirmations that the QSP is ready and able to serve the individuals.

1. The QSP and individual's meet and greet needs to happen before the final confirmation is given that the QSP accepts the referral.

- If the service does not start within the timeframe agreed upon between the individual, QSP and case manager, or within 10 days of accepting the referral, the referral will be rescinded.
 1. Exception: If there has been contact with the case manager, QSP and individual and it is mutually agreed upon that the implementation of the services will be delayed.

NOTE: If QSP shows a pattern of accepting referrals and not setting up care through the QSP Complaint Process, the QSP may be asked to submit proof that they are able to provide the care they have agreed to in the individuals Person Centered Plan Care Plan. (see QSP Complaints)

Qualified Service Provider (QSP) Complaints 525-05-45-30

(NEW 03/01/24 ML #3846)

A Qualified Service Provider (QSP) Complaint is any issue that involves a Qualified Service Provider (QSP) that affects an individual's quality of care, health/welfare/safety, inappropriate billing, potential fraud/waste/abuse, or failure to meet/maintain enrollment standards.

Complaints are categorized by the nature of the complaint which include the following areas.

- Absenteeism
- Abuse/neglect/ exploitation
- Breach of confidentiality
- Criminal History/Activity
- Disrespectful
- Inappropriate Billing
- Care Unacceptable to the Department
- Property Damage
- Self-Neglect
- Providing care under the influence of drugs/alcohol
- Medication errors that result in adverse effects
- Not submitting a critical incident report

Complaint Centralized Intake

A complaint can be made by any person with knowledge of misconduct by a Qualified Service Provider (QSP) or QSP agency.

The ADRL is the official QSP Complaint Intake contact.

- A complaint may be made:
 - by email
 - ADRL carechoice@nd.gov
 - by phone
 - ADRL 1-855-GO2LINK (1-855-462-5465)
 - in writing
 - 1237 W Divide Ave, Suite 6; Bismarck ND 58501

Who should make a complaint?

Anyone who has knowledge or suspects a QSP is not providing quality care or services as outlined in the Person-Centered Plan.

1. A complainant may choose to remain anonymous.
2. Complaint should include:
 - a. Complainant name and contact information.
 - b. Name of the individual who receives care.
 - c. Include as much information as possible about the complaint issue and collateral information.
 - d. Name and/phone number of collateral contacts.

Notification of Complaint to QSP

A Notification of QSP Complaint letter must be sent out to the QSP within 14 calendar days, unless the Program Administrator is directed by law enforcement, VAPS, Protection and Advocacy, or the SURS Program Administrator to wait for them to take further action.

1. The letter is sent through the USPS or to the QSP's valid email address via secure mail and with a return receipt request.
 - a. The letter includes:
 - i. A summary of the complaint against the QSP
 - ii. Request for a response to the allegations
 - iii. Any additional information or releases of information

- iv. Service records
 - v. The provider will be given 20 calendar days to respond to a complaint that does not allege abuse/neglect/or exploitation.
 - vi. If abuse/neglect/or exploitation are alleged, the provider will have 10 calendar days to respond.
2. Response/Service Records from QSP
- a. QSP Complaint Responses are received.
 - i. by email
 - QSPComplaints@nd.gov
 - ii. in writing
 - 1237 W Divide Ave; Suite 6; Bismarck ND 58501
 - b. If a provider does not respond to the Notification of QSP Complaint Letter,
 - The HCBS Program Administrator must have at least one phone contact or attempt leave two voicemail messages with the provider.
 - If the provider still does not respond the complaint may be staffed for a non-response determination of how to proceed.
 - a. If termination is the outcome,
 - i. All billing for the service months records that were requested is to be recouped.
 - ii. If more than \$1000 for an individual provider and \$5000 for an agency provider is being recouped the termination must be staffed with the HCBS/SURS team.
3. Complaint Resolutions
4. Terminated in Progress
- a. The complaint is ended as without further follow-up by the Complaint Administrator as it is clear the complaint is unsubstantiated or does not meet the criteria of a QSP Complaint, or the complaint is a duplicate of a complaint that has already received.
5. Unsubstantiated Complaints

- a. If there is a lack of evidence to substantiate poor care or behavior that has direct bearing on the QSPs ability to provide care.
 - i. A letter is sent to the QSP to inform them of the unsubstantiated finding of the allegations in the complaint.
 - b. If there is a lack of evidence to substantiate poor care or behavior that has a direct bearing on the QSP's ability to provide care, but a review of the service records indicates that a portion of the payment for services should be recouped,
 - i. A letter is sent to the QSP noticing the closing of the complaint and recoupment of any inappropriate payments.
6. Substantiated Complaints
- a. If there is evidence that indicates the complaint is substantiated the state may take the following steps to remedy the situation.
 - b. No Further Action
 - i. If all steps have been taken to remedy the situation no further action will be required.
 - c. Technical assistance
 - i. Corrective Action Plan
 - ii. Recoupment of inappropriate payments.
 - iii. Pre or Post payment review of claims.
 - d. Termination of QSP status.
 - i. QSP may be placed on state and/or federal Medicaid provider exclusion lists.
7. Remediation or Corrective Action Plans
8. Corrective Action Plan
- a. Program may determine that a corrective action plan with specific interventions may resolve the any outstanding concerns substantiated in the QSP complaint.
 - b. Program issue a corrective action plan for the QSP to remediate the substantiated findings.
 - i. A letter outlining the corrective action plan and any payments to be recouped will be sent to the QSP.
9. Termination of QSP
- a. The following steps may occur.
 - i. QSP may be added to State Exclusion List
 - If the provider is to be referred to OIG and/ or put on the state exclusion list the following language must be put in the termination letter to the provider:

- a. Because of this termination, you are not eligible to provide HCBS services to clients whose care is being reimbursed by Medicaid or State and County funds. In addition, because of the circumstances of your termination, your name has been added to the ND State Exclusion list. Section 6501 of the Affordable Care Act requires each State Medicaid program to terminate the participation of any individual or entity that has been terminated for cause under Medicare or by another State Medicaid program. If your name is on the ND State Exclusion list, entities that receive funding from Medicare or Medicaid may face civil monetary penalties if they employ you. This means that you may not be allowed to participate as a provider in any state or work with any organization whose programs are funded by Federal money.
- b. Please be aware this does not impact your eligibility to receive Medicaid or Medicare benefits.
- c. Also, per Federal law, you are being referred to the Office of Inspector General (OIG) and may be excluded from participation in any capacity in Medicare, Medicaid, and all Federal health care programs as defined in section 1128B(f) of the Social Security Act.

**Qualified Service Provider (QSP) Overtime 525-05-45-40
(NEW 3/1/24 ML #3846)**

Purpose

The North Dakota Department of Health and Human Services (HHS) is required to pay individual Qualified Service Providers (QSP) overtime in accordance with the Fair Labor Standards Act (FLSA) In-home care final rule (FLSA Final Rule). In addition, HHS is required to pay at least minimum wage for all authorized hours worked.

Overtime Definition

FLSA Final Rule established that overtime is to be paid at a rate of 1.5 times the regular rate of pay for work in excess of 40 hours in an established seven consecutive day period. Aging Services defines a work week as the seven-day period starting on Saturday at 12:00 a.m. and ending the following Sunday at 11:59 p.m.

- Overtime payments are not required for work completed on weekends or holidays; overtime payments are not automatically paid for care provided on these days unless the time worked on these days otherwise falls within the requirements of overtime.
- The following time may be counted toward weekly hours even though you are not paid for the time spent completing these activities.
 - Drive time, an individual QSP may use Therap to track time spent driving between individual's homes. You may not count the time driving to your first individual's home or driving home after your last individual of the day.
 - Drive time must be tracked in the EVV system.

Who is eligible to receive overtime payments?

Any person enrolled as an Individual QSP who provides care in excess of 40 hours in a work week Saturday through Sunday, may be eligible for an overtime payment.

QSPs must deliver care within the specified scope and duration outlined in their service authorization to maintain eligibility for overtime payments.

Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-40-50 **(NEW 03/01/2024 ML# 3846)**

The FLSA Final Rule recognizes the unique nature of programs in which the care provider and the eligible individual live together and have pre-existing family ties or a pre-existing shared household. There is both a familial or household relationship and an employment relationship.

1. The US Department of Labor Fact Sheet: Application of the FLSA to Domestic Services states the following. "In recognition of the significant and unique nature of paid family and household caregiving in certain Medicaid-funded and certain other publicly funded programs, the Department has determined that the FLSA does not necessarily require that once a family or household member is paid to provide some home care services that all care provided by that family or household member is part of the employment relationship. Where applicable, the Department will not consider a family or household member with a pre-existing close personal relationship with the individual to be employed beyond a written agreement developed with the involvement and approval of the program and the individual (or the individual's representative), usually called a plan of care, that reasonably defines and limits the hours for which paid home care services will be provided."
2. When an individual is eligible and chooses family home care, family personal care, live in daily rate personal care funded under the Home and Community Based Services (HCBS) waiver, Service Payments Elderly and Disabled (SPED), or Medicaid State Plan - Personal Care (MSP-PC) the HCBS Case Manager must complete a person-centered plan of care and a **service agreement** with the eligible individual and their legal decision maker, when the live in paid care provider has a close personal relationship with the eligible individual in need of care.
 - a. A close personal relationship includes relative providers and individuals who had a close personal relationship with the eligible individual prior to paid care being established. Examples include but are not limited to relatives, significant other, or former spouse.
3. Under these programs, the services to be provided and the number of hours of paid services are described in the plan of care, which is based on an assessment of the services the eligible individual requires and is eligible to receive. The person-centered planning process will determine the number of hours care will be provided. That information will be used to create the **service agreement** which covers the scope of the employment relationship, and the services paid under the state and federally funded HCBS. Additional services that are provided beyond the number of hours listed in the service agreement are not reimbursable hours but "natural supports" because of the familial or household relationship.

4. Individuals who are hired to reside in the same household and provide care to an eligible recipient as a paid caregiver are not considered to have a close personal relationship with the eligible individual for purposes of the FLSA Final Rule.
 - a. The Maximum number of hours of care per day that can be paid under Family Home Care, Family Personal Care and SPED-PC Daily Rate is 10 hours.
 - b. The maximum number of hours of care per day that can be paid under Waiver Personal Care – unit rate and Medicaid State Plan – personal care (unit rate) is 12 hours unless prior approval was granted by HHS.

Potential Exclusions from Overtime Payments:

Complaints of Fraud:

If a Qualified Service Provider (QSP) is subject to an open complaint involving a credible allegation of fraud, overtime payments may be withheld until the complaint investigation is complete. Overtime payments will only be released if the complaint is not substantiated, or the number of actual hours worked is not in question.

1. Outstanding Balances:
 - a) Providers with outstanding balances owed to the Department may have overtime payments garnished to settle the balance unless a pre-established payment plan is in effect.
2. Claims Not Supported by an Authorization:
 - a. Overtime will be denied if submitted claims exceed the specified scope and/or duration of services outlined in the pre-authorization and **service agreement**. Claims must align with the authorized service parameters to be considered for overtime payment.
3. Safety Considerations for care providers:
 - a. HHS Adult and Aging Services Section has determined that personal care exceeding 12 hours per day could be considered unsafe if there is only one Individual QSP authorized to provide that amount of care each day. We recommend that no more than 12 hours of personal care be provided to any one eligible individual by the same Individual QSP when daily care is necessary to ensure health and safety.

- b. HCBS Case Managers have been instructed to include a minimum of two Individual QSPs in these situations so the workload can be shared unless an exception was granted by the Department.
 - c. If an exception has not been granted, and an eligible recipient does not want to use an additional provider to receive care beyond the 12 hours of authorized care that information should be documented in the PCP and the risk assessment. In these situations, HHS Adult and Aging Service section is not obligated to authorize additional hours to the chosen QSP. Services may be impacted if the individual is not in agreement with the plan of care.
 - d. There may be circumstances where unit rate QSPs may provide more than 12 hours of care per person (or more than 12 hours combined if serving multiple individuals) only if it is determined that the amount of care they are providing ensures the health and safety of the eligible individual(s). The case shall be staffed with case management and program administration for consideration of an approval exception. Unit rate providers must continue to utilize EVV and are subject to audit.
 - e. Payment including overtime pay may be denied if a provider exceeds a safe working duration for the individual and the case manager has not received approval for an exception in the person-centered care plan to exceed 12 hours of care per day.
4. Failure to Submit Documentation:
- a. Payment for overtime may be denied if a provider fails to submit requested service documentation.
5. Inadequate Documentation:
- a. Overtime payment may be denied if a provider fails to maintain service documentation meeting the Department's outlined requirements.

Service Documentation

Qualified Service Providers (QSPs) are required to maintain required documentation of services provided to eligible individuals. The purpose of this documentation is to verify payment requests and support the quality and integrity of services provided.

The specific elements required in these records are detailed in the provider handbook and must include:

- a. Individual's name
- b. Individual's ND# (North Dakota ID number)
- c. Provider name
- d. Provider number
- e. Service location
- f. Date of service
- g. Time services started
- h. Time services ended
- i. Authorized tasks completed

Documentation Format:

1. Written or electronic documentation of daily services is mandatory and must be completed when services are provided to ensure accuracy.
2. Providers are encouraged to refer to the provider handbook for comprehensive documentation guidelines and to ensure compliance with these requirements.

Timely Submission of Overtime Claims:

1. To facilitate the prompt processing of claims and subsequent overtime, claims for overtime should be submitted within 3 months after the delivery of services.

Audits

To ensure clients are receiving the services they need and to ensure the services provided meet standards set by the Department, HHS may complete an audit of any individual who submits claims for overtime.

1. All QSPs who submits claims for more than 80 hours of care in a week may be subject to an audit of their records.
2. QSPs will receive a notice of audit via email and mail. It will outline the nature of the audit and any findings. It will include information on how to request a review of the audit if the findings are disputed by the provider.

Sanctions

If HHS finds that any payments made to the QSP were inappropriate the Department may request a refund or file adjustments to recoup funds.

1. The QSP will receive an email and a letter stating the circumstances around the adjustment and providing the opportunity to set up a payment plan for the balance owed to the Department. If a payment plan is not set up within 30 days of the notice, the Department will proceed with the adjustment.
2. If it is found that a QSP is not in compliance with the department due to the following examples, all money paid to QSP may be recouped:
 - a. Failure to keep appropriate records.
 - b. If you did not provide the service
 - c. Billing over the authorized amount or billing the wrong code.
 - d. Billing for an authorized task that is utilized in an unreasonable time frame.
 - e. Failure to comply with a request to send records or information.
 - f. Photocopied records, indicating service records were not completed at the time of service.
 - g. Other good cause

Formal Review

If a provider is denied overtime, they will receive a denial letter outlining the dates of service overtime was denied and the reason overtime was denied.

The provider may request a formal review of the denial of overtime payments.

1. A Formal Review may be requested if you disagree with any action regarding provider reimbursement. Per ND Admin Code 75-03-23-12, to request a formal review:
2. Submit a formal written request in writing within 30 days of notification of the adjustment or request for a refund. The notification of adjustment may be contained in the remittance advice or included in a document sent to you by the Department. Within 30 days of requesting a review, provide to the Department all documents, written statements, exhibits, and other written information supporting your request for review. A provider may not request a formal review of the rate paid for each disputed item. The Department has 75 days from the date we received the notice of a request for review to make a decision.

Qualified Service Provider (QSP) Service Agreement -Live In Paid Care Givers Policy Exceptions:

1. All live in caregivers who have a close personal relationship to the eligible individual who are currently providing daily unit rate services should be switched to a daily rate. However, service agreement policy exceptions may be granted by Adult and Aging Services on a case-by-case basis to ensure the health and safety of eligible individuals and access to care in the most integrated environment.
2. If an eligible individual was receiving one of the affected services before March 1st, 2024, and the new policy might significantly change their service cost, making it hard for them to access care, they will be allowed to keep their current rate without any changes. However, a daily rate and service agreement should still be established.
3. Eligible individuals who are using MSP-PC and the QSP is a relative do not have to move to FPC, they can choose what service best meets their needs.
4. If more than one live in QSP is an authorized provider do not use a daily rate. The services should remain as unit rate.
5. If an eligible individual needs less than 3 hours of care per day, do not set up a service agreement or authorize FPC. These services should be set up as daily rate personal care under the applicable funding source and a service agreement would be established.
 - a. For example, if an eligible individual needs less than 3 hours of care per day, what used to be FHC (with a low daily rate) would now be SPED daily rate PC.
 - b. Another example, if an eligible individual lives with their chosen QSP but needs less than 3 hours of care per day, what used to be FPC (with a low daily rate) would now be MSP-PC.

All MSP-PC service providers who have a close personal relationship with the eligible individual are not required to use FPC and remain eligible for MSP-PC. Live in caregivers of this service still need a service agreement and must be switched to the daily rate for easier billing and to comply with FLSA.

6. Live in caregivers will no longer be subject to EVV for these services. Daily rate QSPs will be allowed to attendance bill in Therap. FHC and FPC providers can continue to use paper/atypical claim forms or bill through the MMIS portal.
7. The daily rate for Family Home Care is set at a flat rate as established by legislative action. The number of reimbursable hours of care for this service cannot exceed 10 hours per day. The provider may provide more care than that, but the State is not obligated to pay because that care is being provided because of their close personal relationship.
 - a. To avoid overpayments to live in providers of eligible individuals who need minimal daily care, recipients who need less than 1 hour of care should be switched to SPED-PC daily rate.
 - b. This service must be billed using attendance billing documentation.
8. The daily rate for Family Personal Care is set at a flat rate as established by legislative action.
 - a. To avoid overpayments to live in providers of eligible individuals who need minimal daily care, recipients who need less than 3 hours of care should be switched to MSP-PC daily rate.
9. The QSP can continue to use the paper atypical forms or the MMIS portal for billing.

**Qualified Service Provider (QSP) Service Agreement –
Live In Paid Caregivers, SFN 1654 525-05-60-72
(NEW 3/1/24 ML #3846)**

Purpose:

The North Dakota Department of Health and Human Services (HHS) is required to pay individual Qualified Service Providers (QSP) overtime in accordance with the Fair Labor Standards Act (FLSA) In-home care final rule (FLSA Final Rule). In addition, HHS is required to pay at least minimum wage for all authorized hours worked.

SECTION I: IDENTIFYING INFORMATION

Enter

1. Provider Name
2. QSP Number
3. Service Type
 - a. Family Home Care
 - b. Family Personal Care
 - c. Waiver Personal Care Daily Rate,
 - d. SPED Personal Care Daily Rate
 - e. Medicaid State Plan Personal Care Daily Rate
4. Eligible Individual Name
 - a. The name of the individual the provider is authorized to provide the live in care for.

DISTRIBUTION

File the original copy in the applicant's/individual's case file by scanning into the QSP Service Agreement tab of the Individual Plans section in the Oversight Account of the online case management program within 3 days of completion.

An electronic copy is available through the state e-forms (SFN 1654)
<https://www.nd.gov/eforms/Doc/sfn01654.pdf> .