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** – 06/01/2025

Medicaid Waiver for Home and Community Based Services 525-05-25-10

(Revised 0~~2~~6/01/25 ML #~~3899~~3921)

In order for services to be payable under the provisions of the Medicaid waiver for Home and Community Based Services, the individual receiving the service must meet all of the following:

1. Recipient of Medicaid Program under the State Plan for Medical Assistance as set forth in Service Chapter 510-05, Medical Assistance Eligibility Factors;

2. Age 18 or older and physically disabled as determined by the Social Security Administration or the State Review Team, or be at least 65 years of age;

3. Eligible to receive care in a skilled nursing facility;

4. Participate to the best of their ability in a comprehensive assessment to determine eligibility and develop a person centered plan for receiving home and community-based services as an alternative to institutional care;

5. Have a Person Centered Plan of Care, developed and approved by the individual or legal representative and HCBS case manager that adequately meets the health, safety, and personal care needs of the recipient;

6. Voluntarily choose to participate in the home and community-based program after discussion of available options. This is documented as part of the assurances in the Person-Centered Plan of Care;

7. Service/care is delivered in the recipient's or family member's private family dwelling (house, apartment, or camper if the camper is located in a long term campground that rents by the month/year

etc.) or recipient is receiving a community-based service of adult foster care, adult day care, non-medical transportation, or adult residential service. The service setting must be compliant with the federal HCBS settings rule. The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration.

With the exception of institutional respite, Medicaid Waiver funds may not be used to provide care in any institutional setting i.e. nursing home or hospital.

8. Must receive services on a monthly basis. If a current recipient has not utilized services within a 30-day period of time, a citation *may* be requested (if appropriate) to terminate the case. However, if the services are expected to resume within 3 months, it is allowable for the case to remain open. This does not require approval from a Program Administrator. (See below for service requirements specific to Spousal Impoverishment cases).

   If a current recipient enters a skilled nursing facility or swingbed, and it is anticipated that the length of stay will be 3 months or less, it is allowable for the case to remain open. This does not require approval from a Program Administrator.

   If the individual has not received services because a provider has not been secured, and the individual is still eligible and wants to continue pursuing a provider, the case must remain open. The case manager must make a quarterly contact with the individual. The case manager is required to continue attempts in securing a provider. In doing so, they may need to staff the situation with Aging Services administrators and/or discuss strategies with the individual such as publishing an advertisement for service providers, etc.

   For further instruction and examples, please reference HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

9. Not receiving services through other Medicaid Waivers.

10. The individual's impairment is not the result of a mental illness, intellectual disability or a closely related condition.

Financial Information for Medicaid Waiver HCBS:

1. Spousal Impoverishment

Spousal Impoverishment applies to the Medicaid Waiver programs only. The applicant/recipient must be authorized and receiving a Waiver service on a monthly basis.

Institutional Spouse and Community Spouse (both eligible for Medicaid Waiver Services.

If both of the spouses are residing in the home and are screened at nursing facility level of care (LOC) then spousal impoverishment cannot apply.

When determining spousal impoverishment asset and income limits, see Medicaid Program Service Chapter 510-05. (The amounts change annually.)

2. Charging for Services

If an individual has a recipient liability, it is the responsibility of the provider to collect the individual's share of the cost directly from the individual or their identified legal payee.

3. Handling of Collections

Accounts Receivable Manual, Service Chapter 115-40 shall be followed for all collection procedures.

4. Confidentiality of Financial Records

Financial information regarding a Medicaid waiver recipient shall remain confidential except where otherwise provided by law or departmental policy. (See Accounts Receivable Manual, Service Chapter 115-40.)

5. If the individual's Medicaid was or would be closed due to not meeting recipient liability (after adding the medical expenses, plus the cost of their Medicaid State Plan Personal care) then the individual may receive SPED personal care services if they are otherwise eligible.

6. Overpayment

If there are credible allegations that an individual or their legal representative concealed or misrepresented financial or functional information with the purpose of obtaining eligibility for HCBS, the Department may recoup the overpayment.

Service Payments for the Elderly and Disabled (SPED) 525-05-25-20

(Revised 0~~25~~6/01/25 ML #~~3899~~3921)

In order to be determined eligible for the SPED program, the HCBS Case Manager must submit documentation for the applicant to be entered into the SPED Pool maintained by the HCBS Program Administration.

The HCBS case manager must submit a completed SFN 1820, SPED Program Pool Data, and an SFN 676, Add New Record to MMIS Eligibility File. The information contained in the forms must be based on the completion of the comprehensive assessment.

In addition, the Case Managers must complete an SFN 820, which must be signed by the individual. Only those persons who meet ALL of the following criteria are eligible for entry into the SPED Program Pool. Only those persons who are found eligible and have the SFN 1820 and SFN 676 forwarded to HCBS Program Administration will be pulled from the SPED Pool. Any documentation received incomplete or incorrect will not be entered into the SPED Pool.

1. Functional Eligibility for the SPED Program

    1. If 18 years of age or older, must be the following:

        - The individual is either functionally impaired in at least two (2) Activities of Daily Living (ADLs), OR at least four (4) Instrumental Activities of Daily Living (IADLs), totaling at least four (4) points if living alone, or six (6) points if living with an able-bodied adult.
        - The impairments must have lasted or can be expected to last three (3) months or more (must be noted in the comprehensive assessment narrative of the source of the evidence).

- The applicant/recipient's functional impairments, for which SPED services are being authorized, must be due to a disability which are not the result of a diagnosis of intellectual disability or a related condition or mental illness.
- The individual is living in North Dakota in what is commonly considered a private family dwelling (house, apartment, or camper if the camper is located in a long term campground that rents by the month/year etc.) The private family dwelling must be compliant with the federal HCBS settings rule. The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available, or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration.
- The individual must be capable of directing their own care or have a legal representative to act in their behalf.
- The individual would receive one or more covered services, in addition to Case Management, in accordance with Department policies and procedures for the specific service.

b. If under age 18, must meet the following:

- The applicant has a functional impairment to indicate eligibility.
- The applicant's functional impairment has lasted, or can be expected to last, three months or longer.
- The applicant's functional impairments for which SPED services are being authorized, are not the result of a mental illness, intellectual disability, or a closely related condition.
- The applicant is living in North Dakota in a housing arrangement commonly considered a private family dwelling and not in an institution. For unique circumstances, contact the HCBS Program Administrator for consideration.
- The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan of personal care services.
- The applicant would receive one or more of the covered services under department policies and procedures for the specific service.
- The applicant's parent or legal guardian agrees to the plan of care developed for the provision of home and community -based services.

- The applicant's parent(s) is not responsible for one hundred percent of the cost of the covered service provided, under the SPED sliding fee scales.
- The applicant's parent(s) have not made a disqualifying transfer of assets.
- The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.

- The individual must be screened in need of nursing facility level of care. When completing the LOC screening tool, the "HCBS/Other" check box must be completed.
- For an infant under 3 months of age and requiring apnea monitoring, see the Respite Care section.
- If applying for Family Home Care or Respite Care, see the sections for additional requirements that must be met.
- SPED Personal Care Service is not available for those under age 18.
- Parents are not eligible to be the paid service provider unless prior approval is granted by the HCBS Program Administrator.

2. Financial Eligibility for the SPED Program

- The applicant's resources cannot exceed a total of $50,000 in liquid assets and the value of residence(s) other than the primary residence. See instructions on completion of SFN 820, SPED Income and Asset form.

  Real property (e.g. land or farm) is NOT included in the asset resource determination. However, the income produced by the real property is considered when establishing the applicant's/client's share of the cost of services. If the client has real property from which income is NOT being received AT THEIR DISCRETION and the applicant/recipient continues that arrangement, the income that should have been received must be included in determining the client's fee-for-service participation level.

  Money and assets in a North Dakota Achieving a Better Life Experience (ABLE) Plan are not considered for the purpose of determining financial eligibility to receive

SPED services. See SPED Income and Assets, SFN 820 (525-05-60-20) for specific eligibility guidelines.

- There is an unmet cost for the service(s); that is, the individual is not responsible for 100% of the costs of services delivered.

  State law requires that the individual pay for services in accordance with a fee scale based on family size and income. The HCBS Case Manager must use SFN 820, SPED Income and Asset form, to obtain the information needed to establish the individual's share of the costs.

- The individual has not made a disqualifying transfer of assets.

SPED and Medicaid Eligible

It is not necessary that every SPED Program applicant/recipient make an application for Medical Assistance (Medicaid). During completion of the comprehensive assessment, sufficient information may be obtained to determine whether their assets exceed Medicaid limits. Nor is screening for level-of-care mandatory for all Medicaid recipients.

The Department may not require an individual to apply for services under the state's medical assistance program as a condition of being eligible to apply for services under SPED if the individual's estimated monthly HCBS services benefits which could be covered by MSP-PC or Medicaid waiver (excluding the cost of case management) are between the most current medically needy income level for a household of one plus the $20 disregard established in NDCC 50-24.1-02.6, and the lowest level of the fee schedule for service under this chapter (currently $1,383), or if the individual is receiving a service that is not available under Medicaid or the Medicaid waiver.

The SPED sliding fee schedule will be adjusted each year on July 1, based on the current Social Security cost of living adjustment. Note that this may cause the lowest level of the fee schedule to either increase or decrease.

SPED Fee Schedule	Less the Medically Needy Amt	Less $20 Disregard	Max Service Amt
$1,383.00	($1130.00)	($20.00)	$233.00

The HCBS Case Manager must request this exception from an HCBS Program Administrator when they submit the SPED pool application and note in the case file why the applicant or recipient is not considered eligible for medical assistance or would not meet nursing facility level-of-care or be eligible for Medicaid State Plan (Personal Care). If the service that is being requested is a non-Medicaid Waiver or State Funded service, the applicant/client is not required to apply for Medicaid.

If an individual's services are being paid for at the rural differential rate, determine the cost of the services using the regular rate. If that amount is $233 or less, they are not required to apply for Medicaid. If at any time an individual's service needs increase and the cost exceeds $233 per month, they will be required to apply for MA.

The HCBS Case Manager's first action is to find out if the applicant/recipient is eligible for Medical Assistance; and, if there is a community spouse, if spousal impoverishment applies. This requires the involvement of an eligibility worker. At the same time the eligibility worker is determining Medicaid eligibility, the HCBS Case Manager should determine service need and provider availability.

If an immediate need for service(s) exists, SPED service(s) can be authorized for eligible clients pending determination of Medical Assistance. If it is found that the person does NOT meet eligibility under the Medicaid State Plan services, but does meet SPED Program eligibility, the effective date of the SPED Program will be established to cover those service costs (within the limits of the SPED Program).

When it appears the applicant/recipient may be eligible for Medical Assistance, choosing not to apply for Medical Assistance is the applicant's decision. However, the applicant/recipient is NOT eligible for the SPED Program as a result of refusal to apply for Medicaid or other federal funded programs. If the applicant/recipient's financial resources are determined by the Case Manager to exceed eligibility requirements for Medicaid, the

applicant/recipient is not required to complete the Medicaid application. If the Case Manager is unsure if the individual will meet Medicaid eligibility, the applicant/recipient must request a financial review by the Economic Assistance financial eligibility worker prior to application.

If the applicant/recipient's Medicaid was closed due to not meeting recipient liability, or it is clear that they would not meet recipient liability (after summing the medical expenses, plus Medicaid State Plan Personal Care Services), then the individual may receive SPED Personal Care Services if found eligible through the SPED program.

Institutional Spouse and Community Spouse (Spousal Impoverishment)

Income and Medical Deductions:

If the institutional spouse resides in a nursing home and the community spouse is in need of SPED services:

- All income is counted for the community spouse which would include the deemed income;
- Medical deductions/prescription drugs are counted of community spouse only;
- Household number of one (if no other dependents reside in the home);
- All liquid assets cannot exceed $50,000 for the applicants/client's SPED services, which includes the deemed assets.

If the institutional spouse resides in the personal home or community based setting and the applicant/client needs SPED services:

- All household income is counted, which would include the deemed income;
- Medical deductions (up to the $850 maximum)/prescription drugs are counted for all persons in the household;
- Household number of two (if there are no other dependents residing in the home);
- All liquid assets cannot exceed $50,000, which includes the deemed assets.

Charging for Services

If an individual has a recipient liability or SPED service fee, it is the responsibility of the provider to collect the individual's share of the cost

directly from the individual or their identified legal payee or financial decision-maker.

Confidentiality of Financial Records

Financial information regarding a client shall remain confidential except where otherwise provided by law or departmental policy. (See Accounts Receivable Manual, Service Chapter 115-40).

SPED Eligibility & Medicaid Expansion

If a SPED applicant or recipient is eligible for and/or receiving Medicaid Expansion and is requesting personal care services, the individual must be asked to complete an SFN 1598 Medically Frail Questionnaire to determine if they may be eligible to receive their personal care under traditional Medicaid, unless the cost of the personal care services to SPED is $233 or less per month. The applicant is NOT eligible for the SPED program as a result of refusal to complete this process. If it is determined that the individual is considered to be medically frail and they want to receive personal care services, they must choose traditional Medicaid so they can access Medicaid State Plan personal care.

If the applicant's Medicaid was closed or would be closed due to not meeting recipient liability, (after adding the medical expenses, plus the cost of their Medicaid State Plan Personal care) then the individual may receive SPED personal care services if they are otherwise eligible.

Service Fee, SPED Program

With the completion of the SPED Income and Asset form, SFN 820, and by using the sliding fee schedules, the HCBS Case Manager will determine if a participation fee percentage will be assessed to the service costs.

Refer to Policy 525-05-60-20 SPED Income and Assets regarding the completion of the SFN 820 SPED Financial form and specific Asset, Income, and Deduction information.

Financial eligibility is not complete until the applicant/recipient has signed the SFN 820 indicating the acceptance of the accuracy of the information and service fee. If the service fee is not recorded correctly, the applicant/recipient must be required to sign a corrected page prior to the individual entering the SPED Pool.

Income Verification Method

An income verification method will be used for the individual to indicate family income in all cases. HCBS Case Management staff will review a copy of most recent pay check stubs, bank statements and/or income tax forms to verify the individual's income. If an individual does not supply the documentation, the individual is not eligible to receive or continue SPED services.

All income, assets, and deductions must be verified by the case manager's review of the documents. Case file documentation must contain confirmation they have verified the information for financial eligibility. If the applicant/recipient is receiving Medicaid services, the HCBS case file may cross reference in the file that the verification can be found in the Medicaid eligibility case file.

Financial Status And Family Size Review

The individual's family adjusted gross income and family size shall be reviewed at least every twelve months. In addition, a redetermination shall be made any time a significant change occurs in a family's income or size.

If an applicant/recipient has a spouse who is residing in the nursing home and is receiving Medical assistance under spousal impoverishment rules, consider the spouse requesting SPED services as living in a household of one for both functional and financial eligibility because the institutionalized spouse’s income has already been deemed to the community spouse. If a spouse is receiving services under the Medicaid Waiver and lives in a community-based setting or the home with the applicant/ recipient requesting SPED services, consider it a one-person household for functional eligibility and a two person household for financial eligibility because the spouse is still responsible to pay for room, board etc. If an applicant/ recipient has a spouse who is residing in the nursing home and **both** the applicant and spouse are on Medical assistance, consider the individual requesting SPED services as living in a household of one for both functional and financial eligibility.

If the fee schedule changes, the rate charged will be determined at the next visit. The redetermination fee will not be applied to services delivered prior to the date of redetermination. When the service fee changes, the fee will become effective the first day of the following month when the change was identified.

Financial Disclosure

Each applicant/recipient must provide full financial information upon initial assessment or redetermination, every twelve months thereafter, and at such time that the individual/spouse's income or the family size changes significantly. Individuals not providing full financial information will be billed the full service fee and would, therefore, no longer be eligible for SPED.

An applicant/recipient who refuses to complete SFN 820, SPED Income and Asset form, will not be eligible for the SPED Program.

Individual Fees Charged For Services

Each family member who receives a service for which a fee is assessed shall be charged the fee for that service, in accordance with the billing schedule.

Service Fee Changes

Once services have been established and there is a change to the service fee, the HCBS Case Manager must notify the HCBS Program Administration by submitting an SFN 676 to the Aging Services Division within three working days. **The change in fee is effective the first of the month following the month in which the change occurred.** The coinciding care plan must be signed on/prior to the first of the following month of the effective date in order for the rate change to go into effect. **Fee change requests cannot be retroactive.** If extenuating circumstances exist, contact the SPED Program Administrator for consideration.

3. Ineligibility for the SPED Program

   a. Other Funding Sources

      The individual is NOT eligible for SPED services if their service needs can be met by:

      - Medicaid Waiver for Home and Community Based Services;
      - Medicaid Waiver for Developmental Disabilities (MR);
      - Medicaid State Plan Services;
      - Mental Health Services;

An individual is NOT eligible for SPED if they are eligible for the HCBS Waiver or Medicaid State Plan Personal Care and the cost of their HCBS services to SPED will exceed $233.

Overpayment

If an individual or legal representative provides inaccurate or false information about finances, health status, and/or the ability to complete functional tasks, the Department has the authority to recoup funds. The recoupment may be for payments for services that were provided when the individual was not eligible. An overpayment may be collected from any person that benefitted from or was responsible for the overpayment. A statute of limitations or similar statute does not apply.

b. Disqualifying Transfer

Per NDCC 50-06.2-07, a disqualifying transfer has occurred if at any time before or after making application, the individual or the individual's spouse has made any assignment or transfer of any asset for the purpose of making that individual eligible for benefits. A disqualifying transfer is also transferring of any asset which results in making the individual eligible for benefits or decreasing their SPED cost share. If a disqualifying transfer has occurred per N.D.A.C. 75-03-23-14, the individual is not eligible for the SPED program. However, if all of the transferred assets are returned to the applicant, then the situation could be treated as if no transfer ever occurred.

If a disqualifying transfer occurred five years prior to the date that an individual initially applies for SPED services, the Department will presume that the transfer was not for the purpose of obtaining SPED benefits.

If assets are transferred to a child, grandchild, brother, sister, niece, nephew, parent, grandparent, stepparent, stepchild, son-in-law, daughter-in-law, or grandchild-in-law of the individual or the individuals' spouse as payment made for goods and/or services the amount transferred must be supported by a contractual agreement signed and dated by the SPED applicant/recipient before the goods and/or services were received or provided. Payment for such goods and/or services must be reasonable.

If the applicant/recipient is denied Medicaid based on a disqualifying transfer of assets, the SPED Program applicant/recipient is also ineligible for SPED Program funded services.

An individual is not considered to have made a disqualifying transfer and is not ineligible for SPED if:

- The value of the transferred asset when added to the value of the individual's other assets would not otherwise make them ineligible for SPED or does not decrease the individual's service fee.
- The asset transferred was the title to a home and the home was transferred to the individual's spouse, or to a son or daughter who is under age 21, or who is blind or disabled.
- Assets were transferred to or from the individual's spouse or to another person for the sole benefit of the individual's spouse.
- The individual can show that they intended to dispose of the assets at fair market value as defined in N.D.A.C. 75-03-23-14 and the individual had an objectively reasonable belief that fair market value was received.
- The individual can show that they transferred the assets for a purpose other than to qualify for SPED benefits.
- Where any income or asset is transferred to a relative for services or assistance furnished by the relative, the services or assistance furnished may not be treated as consideration for the transferred income or asset unless:

    1. The transfer is made pursuant to a valid written contract entered into prior to rendering the services, or in the absence of a valid written contract, evidence is provided the services were required and provided.

    2. The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract.

        - There is a presumption that a transfer was made for the purpose of making an individual eligible for SPED if:
            - An inquiry about SPED benefits or benefits under this chapter was made by or on behalf of the individual to any other individual before the date of transfer;
            - The individual or the individual's spouse was an applicant for or recipient of SPED benefits before the date of transfer;

- A transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets would exceed SPED limits; or
- The transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

A transfer is complete when the individual, or the individual's spouse, making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

Contact a HCBS Program Administrator to determine if a disqualifying transfer has occurred.

4. SPED Pool

Upon completion of the comprehensive assessment and the SPED Income and Asset form, AND if it is determined the applicant meets the functional and financial eligibility criteria for the SPED Program, the HCBS Case Manager will forward to the HCBS Program Administration:

- SPED Pool Program Pool Data form (SFN 1820)
- Add New Record to MMIS Eligibility File (SFN 676)

In addition, the Case Managers must transfer the information from the form SFN 820 into the Income and Asset assessment in the web-based data collection system on each person for whom funding is being sought under the SPED Program.

Services must not be authorized until the HCBS Case Manager is notified the applicant was successfully removed from the SPED Pool. HCBS Program Administration will notify the HCBS Case Manager of the decision by forwarding a copy of the SFN 676 with the SPED identification number and start date recorded on the form.

Documents with discrepancies, incompleteness, or apparent ineligibility will not be entered into the SPED Pool and will be returned to the HCBS Case Manager or will be reviewed with the HCBS Case Manager.

When HCBS Program Administration forwards the applicant's identification number and start date to the HCBS Case Manager, the HCBS Case Manager can complete the process for implementing services.

At the time the individual is approved for services funded by the SPED Program, the HCBS Case Manager must re-verify that the person continues to meet the eligibility criteria, develop a care plan and authorize services in accordance with HCBS Case Management.

If a new or current recipient of services has not utilized services within a 30-day period of time, a citation to terminate the case may be requested (if appropriate) from the Program Administrator and an SFN 474 sent too Aging Services if the case is to be closed.

If the individual has not received services because a provider has not been secured, and the individual is still eligible and wants to continue pursuing a provider, the case must remain open. The case manager must make a quarterly contact with the individual. The case manager is required to continue attempts in securing a provider. In doing so, they may need to staff the situation with Aging Services administrators and/or discuss strategies with the individual such as publishing an advertisement for service providers, etc.

If the services are expected to start or resume within 3 months, it is allowable for the case to remain open. This does not require approval from a Program Administrator. The purpose of this exception is to allow eligible individuals to resume services without having to complete the application process again.

- The reason for delay or pause in services must be documented in the individual's file.
- The case manager must document how the need is met while the identified service needs are pending.
- The case manager must follow up monthly with the individual to provide support and assistance mitigating the issue causing the delay in service implementation.

- If the services do not resume or start within 3 months, approval must be received from the Program Administrator to keep the case open OR the case manager must request a termination to close the case and submit an SFN 474 to Aging Services/HCBS.

If a current recipient enters a skilled nursing facility or swingbed, and it is anticipated that the length of stay will be 3 months or less, it is allowable for the case to remain open. This does not require approval from a Program Administrator.

- The case manager must document the admission to the facility.
- The case manager must follow up monthly with the individual and collaborate with the nursing facility/discharge planning team to ensure appropriate services are secured for their return to the community.
- If the services do not resume within 3 months and approval has not been received, the case manager must terminate the case due to institutionalization.

There may be times when a SPED case is closed due to an anticipated long-term admission to a skilled nursing facility, but the circumstances change and the individual is able to discharge back to the community. For those instances:

If a SPED recipient closed due to a skilled nursing facility or swing bed admission, but they re-open SPED within 3 months:

- A new Application for Services (SFN 1047) does not need to be completed.
- A new SPED financial assessment (SFN 820) does not need to be completed unless there has been a substantial financial change, or the individual is due for a required annual assessment.
- An SFN 1820 does not need to be completed.
- An SFN 676 does need to be completed and submitted to HCBS/Aging Services. If all information is the same, it is allowable to use the previously approved SFN 676 and simply indicate the date the individual is to re-open in the field "Date of Application" and select "Re-Open" in the "Application Type" field.

For further instruction and examples, please reference HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

SPED Pool Exceptions

As long as the individual still meets all eligibility criteria, the individual does not have to go through the SPED pool to receive SPED services if one of the following applies:

- Individual was discharged from an inpatient hospital stay, skilled nursing facility, swing bed facility, long term care facility, or basic care facility and has been off the SPED program for fewer than 3 months
- Individual has been off the SPED program for 60 days or less for any reason

The HCBS Case Manager must document the date that SPED services re-should start on the SFN 676, Add New Record to MMIS Eligibility File, in the "Date of Application" field and select "Re-open" in the "Application Type" field. For further instruction, please reference HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

The HCBS Case Manager should also include a request for an exception to apply for Medicaid on these forms if the applicant will be receiving personal care but the cost of their services are less than $233. If SPED personal cares are to be authorized, the Case Manager must complete the bottom section of the SFN 1820, outlining the estimated amount of SPED Personal Cares, and an Explanation as to why they are to be funded by SPED and not Medicaid State Plan Personal Care Services.

Expanded Service Payments for the Elderly and Disabled Eligibility (ExSPED) 525-05-25-25

(Revised 0~~2~~6/01/25 ML #~~3899~~3921)

Eligibility for the Expanded SPED Program has two components: financial/Medicaid eligibility and functional eligibility. The applicant/individual must meet BOTH eligibility components before payment can be made by the Department under this Chapter.

1. Functional Eligibility, ExSPED Program

    a. Is at least 65 years of age, OR is at least 18 years of age and disabled or blind based on Social Security criteria. N.D.C.C. 50-24.7-01(5)(b);

b. Is not severely impaired in ANY of the three activities of daily living (ADLs): Toileting, Transferring to or from a bed, chair or toilet, or Eating as determined by completion of an comprehensive assessment.
c. Is impaired in at least three (3) of the following four (4) instrumental activities of daily living (IADLs): Meal Preparation, Housework, Laundry, or Taking Medicine based on completion of a comprehensive assessment. The impairments must have lasted or are expected to last, more than three (3) months.

(**Note**: Or has health, welfare, or safety needs, including a need for supervision or a structured environment, which otherwise require care in a licensed adult family foster home or a licensed basic care facility. (The services of the Expanded SPED Program are provided in the recipient's home or community instead of care in a basic care facility.)

d. Capable of directing own care or has a legal representative to act in their behalf.

e. Living in what is commonly considered a private family dwelling (house, apartment, or camper if the camper is located in a long term campground that rents by the month/year etc.). The private family dwelling must be compliant with the federal HCBS settings rule. The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration.

f. The applicant impairment is not the result of an intellectual disability or a closely related condition.

g. Service/care need is within the scope of services available under this chapter;

2. Financial Eligibility for ExSPED

a. The first step is to have a determination of Medicaid eligibility by the Economic Assistance Unit, as an applicant must be receiving Medical Assistance in order to be eligible for ExSPED.

In addition to being eligible for Medical Assistance, the applicant must be receiving Supplemental Security Income (SSI) OR, if not, their income cannot exceed an amount equal to SSI. [N.D.A.C. 75-02-10-05(4)]. Please note that the following income is disregarded:

Recovery Rebates authorized by section 2201 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 [Pub. L. 116-136].

b. Estate Recovery

Any monies paid from general funds for Ex-SPED services are subject to estate recovery by law, N.D.C.C. §50-24.7-05. This includes the following services:

- Adult Day Care
- Adult Foster Care
- Chore & ERS
- Environmental Modification
- Family Home Care
- Companionship
- Home Delivered Meals
- Homemaker
- Non-Medical Transportation
- Respite

Legislation passed during the 1995 session gives the Department the authority to file a claim against an individual's estate to recover payments made under the Expanded SPED Program. The Department can file a claim for all payments made since the inception of the Program in 1994.

c. Overpayment

If an individual or legal representative provides inaccurate or false information about finances, health status, and/or the ability to complete functional tasks, the Department has the authority to recoup funds. The recoupment may be for payments for services that were provided when the individual was not eligible. An overpayment may be collected from any person that benefitted from or was responsible for the

overpayment. A statute of limitations or similar statute does not apply.

d. Ongoing Medicaid Eligibility

Because Medicaid eligibility is part of the financial eligibility for ExSPED, the individual's Medicaid status will need to be verified periodically. The HCBS Case Manager should verify in MMIS that the individual continues to have an active Medicaid case as part of the regularly scheduled quarterly contacts and home assessments.

3. Expanded SPED Pool

Upon finding the applicant meets the criteria for the Expanded SPED Program through the completion of the comprehensive assessment and verification from the Eligibility worker, forward the following to the HCBS Program Administration:

- Expanded SPED Pool Program Data form SFN 56
- Add New Record to MMIS Eligibility File (Expanded SPED) SFN 676

Services must not be authorized until the HCBS Case Manager is notified the applicant was successfully removed from the ExSPED Pool. HCBS Program Administration will notify the HCBS Case Manager of the decision by forwarding a copy of the SFN 676 with the ExSPED identification number and start date recorded on the form.

Documents with discrepancies, incompleteness, or apparent ineligibility will not be entered into the ExSPED Pool and will be either returned to the HCBS Case Manager.

When HCBS Program Administration forwards the applicant's identification number and start date to the HCBS Case Manager, the HCBS Case Manager can complete the process for implementing services.

If a new or current recipient of services has not utilized services within a 30-day period of time, a citation to terminate the case may be requested from the Program Administrator (if appropriate) and an SFN 474 sent to Aging Services if the case is to be closed.

If the individual has not received services because a provider has not been secured, and the individual is still eligible and wants to continue pursuing a provider, the case must remain open. The case manager must make a quarterly contact with the individual. The case manager is required to continue attempts in securing a provider. In doing so, they may need to staff the situation with Aging Services administrators and/or discuss strategies with the individual such as publishing an advertisement for service providers, etc.

If the services are expected to start or resume within 3 months, it is allowable for the case to remain open. This does not require approval from a Program Administrator. The purpose of this exception is to allow eligible individuals to resume services without having to complete the application process again.

- The reason for delay or pause in services must be documented in the individual's file.
- The case manager must document how the need is met while the identified service needs are pending.
- The case manager must follow up monthly with the individual to provide support and assistance mitigating the issue causing the delay in service implementation.
- If the services do not resume or start within 3 months, approval must be received from the Program Administrator to keep the case open OR the case manager must request a termination to close the case and submit an SFN 474 to Aging Services/HCBS.

If a current recipient enters a skilled nursing facility or swingbed, and it is anticipated that the length of stay will be 3 months or less, it is allowable for the case to remain open. This does not require approval from a Program Administrator.

- The case manager must document the admission to the facility.
- The case manager must follow up monthly with the individual and collaborate with the nursing facility/discharge planning team to ensure appropriate services are secured for their return to the community.
- If the services do not resume within 3 months and approval has not been received, the case manager must terminate the case due to institutionalization.

There may be times when an ExSPED case is closed due to an anticipated long-term admission to a skilled nursing facility, but the circumstances change and the individual is able to discharge back to the community. For those instances:

If an ExSPED recipient closes due to a skilled nursing facility or swing bed admission, and they re-open SPED within 3 months:

- A new Application for Services (SFN 1047) **does not** need to be completed.
- An SFN 56 **does not** need to be completed.
- An SFN 676 **does** need to be completed and submitted to HCBS/Aging Services. If all information is the same, it is allowable to use the previously approved SFN 676 and simply indicate the date the individual is to re-open in the field "Date of Application" and select "Re-Open" in the "Application Type" field.

For further instruction and examples, please reference HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

Expanded SPED Pool Exceptions

As long as the individual still meets all eligibility criteria, the individual does not have to go through the Ex-SPED pool to receive Ex-SPED services if one of the following applies:

- Individual was discharged from an inpatient hospital stay, skilled nursing facility, swing bed facility, long term care facility, or basic care facility and has been off the Ex-SPED program for fewer than 3 months
- Individual has been off the Ex-SPED program for 60 days or less for any reason

HCBS Case Management 525-05-30-05

(Revised 0~~2~~6/01/2025 ML #~~3899~~3921)

Purpose

Case Management is a service that assists individuals in learning about, applying for, accessing and maintaining home and community-based services in the most integrated setting appropriate to their needs.

The purpose of HCBS Case Management is to assist an individual to achieve and maintain independent living, in the living arrangement of their choice, until it is no longer appropriate or reasonably possible to maintain or meet the individual's needs in that setting. In order to facilitate independent living, the HCBS Case Manager leads the person-centered planning process that enables individuals and their natural and formal supports to explore and understand long-term service and support (LTSS) options, identify barriers, set goals, and collaborate with stakeholders to assist the individual in accessing needed community-based services. The HCBS Case Manager also advocates for and promotes individual-focused systems of service delivery, exercises an awareness of the larger target population in need, and exercises prudence in each individual's person-centered plan of care to link individuals with resources and services, utilizing those services and resources effectively.

HCBS Case Managers perform waiver functions at the local level. The functions performed by the HCBS Case Managers include:

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

<u>Standards for HCBS Case Managers</u>

HCBS Case Management must be provided by state employed HCBS Case Managers. HCBS Case Managers must be:

- Employed by HHS, Aging Services, as an HCBS Case Manager,
- Social Worker licensed to practice social work in North Dakota.
- Registered nurse, licensed to practice in the North Dakota.
- Meet all the requirements.

HCBS Case Management is provided by state employed HCBS Case Managers. Effective 1/1/2025, HHS, Aging Services administratively claims for the service of HCBS Case Management for HCBS Waiver participants.

HCBS Case Management includes assisting individuals in accessing and receiving Home and Community Base Services. HCBS Case Managers are responsible for:

- completion of the HCBS comprehensive assessment,
- level of care screening,
- person-centered planning,
    - including care plan development, assessment, monitoring, and completing the plan,
- monitoring,
- reassessment,
- implementation of the person-centered plan
    - including assisting the eligible individual to explore and understand options, make informed choices, solve problems, provide a link between community resources and qualified service providers, and closure and termination of services.

1. HCBS Case Managers employed by Aging Services provide the service of Case Management for the Aging Services Programs of Service Payments for the Elderly and Disabled (SPED) and Expanded Service Payments for the Elderly and Disabled (EXSPED).

2. Agencies who are enrolled as a QSP for the Service of Case Management are eligible to receive payment for the service of Case Management as HCBS Care Coordination under the HCBS Waiver.

Policy on Case Management provided as HCBS Care Coordination can be found at the services chapter HCBS Care Coordination 525-05-30-07.

Case file documentation must be maintained:

1. In a secure setting

2. On each individual, in separate case files

Quarterly Visit Requirements for Medicaid Waiver

Case Managers are required to monitor during their quarterly face-to-face contacts to ensure an individual's is being afforded the rights of privacy, dignity and respect, and freedom from coercion and restraint (including the limited use of restraints that are allowable under Adult Residential Services in accordance with NDCC 50-10.2-02 (1)).

- Any violation of an individual's rights must be reported as complaint to the HCBS Program Administrator and/or Vulnerable Adult Protective Services.
- If a restraint or restriction is identified, the case manager must document the restraint or restriction on the Person-Centered Plan of Care and review the need for the restriction at a minimum of every six (6) months.

Standards for Targeted Case Management (TCM) for persons in need of Long-Term Care is found in the following chapter Medicaid State Plan, Personal Care Services policy 535-05-35.

- ~~The service shall be performed by~~
  - ~~A social worker or agency that employs individuals licensed to practice social work in North Dakota and who has met all the requirements to be enrolled as either an Agency Qualified Service Provider (QSP)~~
  - ~~or an Indian Tribe/Indian Tribal Organization who has met State Plan requirements and requirements to be enrolled as a QSP~~
  - ~~or Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disabilities Professionals (QDDP) or has one year experience as a DDPM with the Department.~~

~~The following enrolled provider types are eligible to receive payment for TCM:~~

- ~~Case Managers employed by Aging Services who have sufficient knowledge and experience relating to the availability of alternative long-term care services for elderly and disabled individuals.~~
- ~~Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disabilities Professional (QDDP) or has one year experience as a DDPM with the Department.~~

- Indian Tribe or Indian Tribal Organization who has met the provider qualifications outlined in the North Dakota State Plan Amendment.

The following enrolled provider types are eligible to receive payment for TCM and Authorize Service(s):

- Case Managers employed by Aging Services are eligible to approve services under SPED, EXSPED and Medicaid State Plan - Personal Care (MSP-PC), (see Chapter 535-05).
- DDPMs are eligible to approve MSP-PC services.
    - If the individual is a recipient of services funded by the SPED, Expanded SPED Programs, or MSP-PC the one case file will contain documentation of eligibility for TCM as well as for the service(s).

The following enrolled provider types are eligible to receive payment for **single event TCM**:

- HCBS Case Managers, DDPMs and enrolled Indian Tribe or Indian Tribal Organizations.
    - If the individual requests a contact more than once every six months, the Case Manager needs to obtain prior approval from a HCBS Program Administrator.
    - Indian Tribe or Indian Tribal Organizations are limited to providing TCM Services to enrolled tribal members.

Targeted Case Management (TCM)

The individual receiving TCM will meet the following criteria:

1. Medicaid recipient.
2. Not a recipient of HCBS (1915c Waiver) services.
3. Not currently being covered under another case management/targeted case management system or payment

~~does not duplicate payments made under other program's authorities for the same purpose.~~

~~4. Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or resides in a nursing facility if it is anticipated that a discharge to alternative care is within six months.~~

~~5. Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the age of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.~~

~~6. Has long-term care need (need anticipated to exceed 30 days). Document the required long-term care need on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.~~

~~The applicant or referred individual must agree to a home visit and participate in the assessment and person-centered planning.~~

~~Activities of Targeted Case Management~~

~~1-Assessment/Reassessment~~

~~2-Person Centered Plan Development~~

~~3-Referral and Related Activities,~~

~~4-Monitoring and Follow-up Activities~~

~~(Details outlined in section- HCBS Case Management – Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities)~~

- ~~The focus or purpose of TCM is to identify what the individual needs to remain in their home or community and be linked to those services and programs.~~

- ~~An assessment must be completed, and a person-centered plan developed. The individual's case file must contain documentation of~~

~~eligibility for TCM. The HCBS Comprehensive Assessment and narrative must be entered into the web-based data collection system.~~

- ~~The case record must include a HCBS Comprehensive Assessment and narrative (entered into the web-based data collection system) which includes:~~
  - ~~Name of the individual~~
  - ~~Dates of case management service~~
  - ~~Name of the case management provider/staff~~
  - ~~Nature, content, units of case management service received, and whether goals specified in the plan are achieved~~
  - ~~Whether the individual has declined services in the care plan~~
  - ~~Coordination with other case managers~~
  - ~~Timeline of obtaining services~~
  - ~~Timeline for reevaluation of the plan~~

~~Limits:~~

~~Case management does not include direct delivery of services such as counseling, companionships, provision of medical care or service, transportation, personal care, homemaker services, meal preparation, shopping (this is not an all-inclusive list).~~

~~Case file documentation must be maintained:~~

1. ~~In a secure setting~~
2. ~~On each individual, in separate case files~~

HCBS Case Management - Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities

HCBS Case Management Service consists of the service activities or components listed below.

1. Assessment of Needs - This component is completed initially and at least every six months thereafter. At least one home visit is required during the initial assessment of needs process.

    - The case manager must schedule an appointment for an initial assessment no later than 5 business days after receiving a request for home and community-based services (HCBS) and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for HCBS. All contacts with an individual must be documented in the case file.

      Exception: In cases where the HCBS referral is initiated through ADRL Transition or MFP Transition Services by Money Follows the Person (MFP) and HCBS Case Management, the HCBS Case Manager may follow the established timeline of MFP Transition Coordination.

        - MFP Transition Coordination reaches out to the referred individual within 5 working days of the referral and facilitates a Transition Team meeting to initiate the referral within 14 days of the referral. The start date of the referral for HCBS case management is the date that the MFP transition coordinator reaches out to the team to schedule the transition team meeting.

Individuals must sign and be given a "Your Rights and Responsibilities" brochure DN 46 annually and a signed copy of this must be kept in the individual's file.

During the assessment process, when applicable, the information needed for submission to Maximus is obtained. The case management entity must use the existing and established procedures for requesting a level-of-care determination from Maximus.

For an adult (at least 18 years of age): Complete the HCBS comprehensive assessment and gather input from other knowledgeable persons as authorized by the applicant/individual.

For a child (under 18 years of age): Complete the HCBS Comprehensive assessment AND submit the necessary documents to Maximus for a level-of-care determination.

The following service combinations require approval by the HCBS Program Administrator as indicated in the chart below;

Approval	Description	Frequency
Hospice	Pre-approval is not needed. However, the combination of HCBS services and hospice service requires documentation in the case note that the individual continues to meet eligibility for the service and there is no duplication of services. The hospice service must also be noted on the "other community-based services" section of the person-centered plan. For MSP-PC cases only: The following information must also be sent to provider enrollment: • Name of the individual • ND number • Date hospice started • Provider name • provider number • Document in the email assurance that the hospice plan is on file (the hospice plan must be kept in the individuals HCBS file.)	One-time
FPC	Approval is needed when the Family Personal Care provider is a legal spouse or legal guardian. Include name, county, name of proposed provider, and why the person acting as the FPC provider is in the best interest of the individual.	One-time
Out-of-state care	SPED, ExSPED, and HCBS Medicaid waiver: If you are seeking to continue to authorize services for an individual while they are out of state: Include name, county of residence, funding	Each instance

	source, description of situation for consideration, including whether medical treatment is being sought out of state. For MSP-PC: the individual and/or provider must inform the case manager of the dates and location they are traveling out of state for which care is provided. The case manager documents this in the narrative. However, prior approval from administration is not required for MSP-PC.	
FHC/FPC combined w/ any other service other than Respite, ERS, N-ED, EPCS, EPCS-N	Include name, county of residence, funding source, why the additional service is needed and/or cannot be provided by FHC or FPC provider.	One-time
FHC/FPC provider working full-time	Include name, county of residence, funding source, how individual needs will be met and not delegated, how safety will be assured, hours and times of provider working, etc.	One-time
More than 1 FHC/FPC provider for an individual	Include name, county of residence, funding source, why the individual requires more than one FHC or FPC provider to meet their needs, how cares will be provided daily.	One-time
Waiver Personal Care by live-in family member	~~If an outside provider is the primary caregiver and the live-in-family member provides supplemental cares only, the live in family member provider may be eligible to receive WPC unit rate services limited to the cap for live-in family providers with prior approval of Program Administration. Waiver Personal Care unit rate services may be authorized to supplement the care provided by the primary care provider. Include name, county of residence, description of need/functional status, why it is not appropriate for live-in family member to provide Family~~	One-time

	~~Personal Care, amount (hours per day) of care provided by outside provider as well as amount (hours per day) of care provided by live-in family member.~~ The intent of WPC is not to replace or duplicate FHC or FPC. If unique circumstances exist, include name, county of residence, funding source, description of circumstance for consideration.	
Supervision for live-in provider	If an individual is requesting Supervision authorized by a live-in provider, including a provider hired by an agency, include name, county of residence, funding source, description of circumstance for consideration.	One-time
Chore	When the cost of chore labor is over $500/month, or to approve specific tasks such as professional sanitation, floor care of unusual nature, etc. per policy. Include name, county of residence, funding source, description of need, task, provider, frequency, cost estimate.	Each instance
Residential Habilitation or Community Support	Include name, county of residence, ND number, medical diagnoses, a description and breakdown of all tasks needed, and the number of units needed on average each day or in one month.	One-time, changes
Nurse Education/EPCS	Include name, county of residence, funding source, medical diagnoses, list of medications, list of medical tasks needed.	Each instance
Environmental Modification	Must have prior approval for all. Include name, county of residence, funding source, and description of request. Once approved to proceed, include copy of written recommendation by professional to ensure modification will meet the needs (if cost over $500), name of who owns/rents home, current value	Each instance

	of home if owned, bids, and proposed dates of services.	
Specialized Equipment	Must have prior approval for all. Include name, county of residence, funding source, and description of request. Once approved to proceed, include copy of written recommendation by professional to ensure modification will meet the needs (if cost over $500), name of who owns/rents home, current value of home if owned, bids, and proposed dates of services.	Each Instance
2-person assist	If more than one provider is needed to complete a service or task, include the name, county of residence, funding source, and description of need – why one provider is unable to safety complete the service or task.	Initial, every 6 months
~~MSP Level C~~	~~Include name, county of residence, description of need/functional status, number of personal care units/and assurance that no units are authorized for l/s/h~~	~~Initial, every 6 months~~
Respite when primary caregiver does not reside w/ recipient	Include name, county of residence, funding source, and explain why respite care is appropriate (example: the primary caregiver provides frequent on-site visits throughout the day which is essential to allow the individual to live independently).	Annual
Respite Care provider who resides w/ recipient	Include name, county of residence, funding source, and explain why it is appropriate for the live-in caregiver to be authorized to provide respite care.	Annual
Case remaining open when recipient in NH for over 3 months	Include name, county of residence, funding source, date of nursing home admission, and information related to pending discharge plans back into the community/receipt of HCBS.	Annual
Reasonable Modifications	For reasonable modification requests, include all necessary information that is indicated on the reasonable	Reasonable modifications need to be re-

	modification template. For annual re-approval of a reasonable modification, include the information indicated on the reasonable modification template, as well the date of original approval and whether the modification needs to be modified or should continue.	approved on an annual basis during the annual review or any time there is a change
Exceptions to services/ combinations/ situations not otherwise listed	Include name, county of residence, funding source, services, and detailed description of the request for approval. If a reasonable modification request, include the age of the individual, whether they would reasonably meet LOC, if they are on Medicaid or at risk of being on Medicaid, and why the approval would assist in preventing institutionalization/possible detrimental outcomes of not approving the request.	As needed depending on request

If the individual referred to HCBS appears to potentially meet the criteria for ID/DD waiver, the case manager may contact an HCBS Program Administrator to request an interdisciplinary team staffing to determine the options available to meet the individuals request for services.

2. Person-Centered Planning

Person-Centered Planning (PCP) is a way of thinking about a person as a whole. PCP is a way to develop a plan using both formal and natural supports to address all areas that are important to the individual. PCP is a process, not a procedure or document. HCBS case management has been utilizing PCP with the current assessment and care planning process. Utilizing the Charting the LifeCourse (CtLC) framework allows HCBS to enhance our PCP practices by really focusing on what matters to the individuals, what the individuals need to live the life they want and how they can be supported to meet their needs. PCP encourages community integration and recognizes the individual's preferred role in the community. The case manager assists the individual to overcome barriers that

prevent them from living their best lives in the most integrated setting appropriate.

The purpose of person-centered planning is to identify, arrange, and maintain the supports and services necessary to meet the individual's needs in the most integrated setting, consistent with the member's informed choice as appropriate to the individual's needs.

Person centered plans will be developed with input at a minimum from:

1. The individual to the fullest extent possible, including when the member has a legal guardian, consistent with state law N.D.C.C. 30-1-28-12. The individual will have the primary role in developing the person-centered plan when possible.

2. The individual's family and/or friends with permissions and desire of the individual; and

3. The individual's legal guardian, where applicable, to the extent the guardianship order confers residential and/or medical decision-making upon the guardian per N.D.C.C 30.1-28-04(5).

Any decision(s) made by the guardian about where the member will receive services should reflect the member's preferences, as documented in the person-centered plan, to the fullest extent possible. See N.D.C.C. 30.1-26-01(3).

Case managers should facilitate a process to resolve conflicts that arise during the person-centered planning process if the individual and their family/natural supports or guardians do not agree on where the individual should live and receive services.

Role of Case Manager in Person-Centered Planning

The role of the case manager in the PCP process is to lead and facilitate conversations with the individual requesting or receiving home and community-based services. Person-centered planning is a way of developing a care plan that takes all aspects of what is important to an individual into consideration. The role of the case manager has four components.

1. Request for an assessment/reaching out for services.

The role of the case manager during this phase is to gather information. Identify who is most important to the person and who they would like to be on their team. Discuss with the individual what your role is as a case manager and what you will be discussing at the home visit. Invite them to ask friends, family or other supports to be present at the assessment if they would like. An individual may wish to invite their QSP to the assessment planning process to ensure an understanding of what services are needed and the preferences of the individual. Remind the individual of the sensitive information that you will be discussing at the visit.

2. Assessment

The case manager will engage in facilitated discussion with the individual requesting services. The case manager utilizes the HCBS Comprehensive Assessment, the Vision Tool and the Risk Assessment and Health and Safety Plan with every individual initially, annually, at six-months and when there are significant changes. When a case manager is completing the assessments and vision tool the individual may be asked to provide information about themselves, such as what is important to the individual, are there community supports or other formal supports that they are involved in? What roles does the individual have in life, such as do they identify as a friend, mother, grandmother, employee, friend, church member, quilter, wood carver, card player, veteran? How can the case manager support the individual to continue in their role? Through these conversations you will be discussing the life domains that are identified in the Charting the LifeCourse Vision tool. Additionally, the financial assessment and caregiver assessment may need to be completed.

The case manager must document in the assessments and vision tool the exchange of information between the individual and the case manager. Additionally, collateral information from the individuals care team may be included. If an individual does not wish to discuss information or questions in the assessment or vision tool, the case manager must document in that area the individuals wish to not answer the questions or discuss the topic.

For each functional impairment identified the functional assessment note must include:

- the reason the individual is unable to complete the task and/or why the individual is impaired,
- who is completing the task, how this need is met.

If the need is met through HCBS, the functional assessment must also include the following information:

- Who assists with the task,
- What service the task falls under
- The overall number of units authorized for this service type
- The anticipated outcome or goal.

3. Developing the plan

Case managers will use the information gathered through the assessment process to coordinate with the individual and team members on an action plan that meets the needs of the individual and reflects their preferences. The plan will be reviewed and updated at least every 6 months, upon individual request, or as situations arise. The PCP of care is based off of the facilitated discussion. Components of the person-centered plan of care includes the Charting the LifeCourse, (CtLC) Vision tool, formal and natural supports, strengths, barriers, unmet needs, services offered and declined, timelines and strategies to meet the individual's goals. Additionally, the Risk Assessment and Health and Safety Plan must be completed.

- **For Basic Care ONLY, the Basic Care Personal Care Services Plan of Care and Authorization of Services in a Basic Care Setting, ~~SFN 662~~, must be completed annually. DO NOT complete the Vision Tool, Person-Centered Plan of Care or the Risk Assessment and Health and Safety Plan for Basic Care. The Basic Care Personal Care Services Plan of Care and Authorization of Services ~~SFN 662~~ must be submitted to Aging Services via the individual's web-based case file ~~the HCBS Submission Fax Line~~.**

For Medicaid Waiver, Service Payments for the Elderly and Disabled, Expanded Services Payments for the Elderly and Disabled and Medicaid State Plan – Personal Care Services the following procedures for the person-centered plan of care applies:

The person-centered plan of care (PCP) includes the Vision Tool, Person-Centered Plan of Care, the preauth in Therap and the Risk Assessment and Health and Safety Plan. Additionally, the plan may include the caregiver assessment, transition plan, and/or the Individual Program Plan.

Adult Residential Care

When completing the person-centered plan of care for HCBS Medicaid waiver, service Adult Residential Care: upon receipt of referral, the case manager first completes the initial assessment as well as the level of care screening and the care plan.

If Medicaid is pending determination, the case is pended until notification of Medicaid approval is received by Medicaid eligibility. When Medicaid eligibility notifies case management that Medicaid is approved and the effective date of Medicaid, the case manager can proceed with opening the waiver services.

- The effective date of the waiver service cannot be prior to the date all of the following waiver eligibility criteria are met:
  - Medicaid effective date,
  - Application for Services,
  - Completion of the HCBS Comprehensive Assessment
  - Approval of the NFLoC
  - HCBS Care Plan is completed and signed.

Example: A referral is received for ARC on January 15th. The individual has applied for Medicaid and eligibility is pending determination. The case manager goes out to see the individual. The case manager completes the Application for Services, HCBS Comprehensive Assessment, NFLoC and HCBS Care Plan on January 25th. The case manager communicates to Medicaid eligibility that the assessment is complete and individual meets functional eligibility, then holds the case as pending until Medicaid eligibility is determined.

The case manager is then notified on February 20th that Medicaid was approved with an effective date of January 1st. The effective date of Medicaid Waiver is January 25th as this is the date that all waiver eligibility criteria is met.

When completing the person-centered plan of care the case manager will refer to the functional assessment section of the HCBS Comprehensive Assessment to review and discuss with the individual the services and scope of the tasks (limits to the tasks) that can be provided through HCBS. The discussions on services may require gathering additional information as follows:

- In order to authorize the task of vital signs, the case manager must have on file: a written, signed recommendation (provided by a nurse or higher credentialed medical provider) outlining the requirements and frequency of monitoring. For the task/activity of exercise, a written recommendation and an outlined plan by a therapist for exercise must be on file.

The HCBS Case Manager must review with the individual or the individual's representative the following information about qualified service providers (QSP) available to provide the service and endorsements required by the individual:

- Name, address and telephone number of QSP.
- Whether QSP is an agency or individual.
- The unit rate per QSP.
- If applicable, limitations of the QSP available.
- If applicable, endorsements for specialized cares:
    - Global Endorsements (Only a QSP who carries a global endorsement may provide these activities and tasks. Refer to the QSP list to determine which global endorsements the provider is approved to provide.) Global Endorsements include: Cognitive/Supervision, Exercises, Hoyer Lift/Mechanized Bath Chair, Indwelling or external Bladder Catheter, Medical Gases, Prosthesis/Orthotics/Adaptive Devices, Suppository, compression sleeves or ~~TED~~ Socks (e.g. TED Socks), and Temperature/Blood Pressure/Pulse/Respiration Rate.
        - On the Preauth document the name of the agency or person who is to be contacted to provide the results of the individual’s blood pressure, pulse, rate of respiration, or temperature.

- Client Specific Endorsements: These activities and tasks may be provided only by a provider who has demonstrated competency and a Request for Client Specific Endorsement, SFN 830, is on file in the individual's file. The provider must obtain documentation that a health care professional has verified the provider's training and competency specific to the individual's need and provide a copy to the Case Management Entity. The Case Management Entity must forward a copy of the SFN 830 to HCBS Program Administration. Client Specific Endorsements include: Apnea Monitoring, medically prescribed compression device ~~JOBST Stockings~~, Ostomy Care, Postural/Bronchial Drainage or Nebulizer Treatment, ~~RIK~~ pressure relieving mattress ~~Bed Care (Specialty Beds)~~.

Qualified Service Providers who can provide the required care and whom the individual has selected will be listed on the HCBS Care Plan and PreAuth.

- When a change in service provider occurs between case management contacts – the individual or legal representative may contact the case manager requesting the change in provider. The contact and approval for the change in provider must be verified in the case manager's documentation and noted on the person-centered plan of care.

- A copy of the updated care plan must be sent to the individual or legal representative. However, changes in services or the amount of service must be signed by the individual or legal representative and approved.

The service, amount of each service to be provided, the costs of providing the selected services, the specific time-period, and the source(s) of payment are recorded on the HCBS Care Plan and PreAuth.

- Individuals must be made aware of funding caps and documentation must verify that the individual has been informed of the service limits when developing the care plan at a minimum of every 6 months. If an individual's needs exceed the service limit, they would be issued a denial notice and would have the right to appeal. Or contact the HCBS Program

Administration to request an exception or reasonable modification to meet the individual need if the individual is at risk of institutional placement.

Contingency plans

- Contingency planning must occur in all person-centered plans of care. The backup provider or plan must be listed on the HCBS Care Plan.

The case manager must review with all individuals and/or the individual's representative the individual stated goal. The goal must be recorded as part of the Person-Centered Plan of Care. The individual goals must be reviewed and updated annually, every 6 months and as significant changes in the individual's needs occur or if the individual requests an update.

The final step in Care Planning is to review the completed HCBS Care Plan, with the individual/legally responsible party and obtain required agreements/acknowledgments and signatures.

When services are reduced, you must provide the individual or their legal representative.

In situations where the individual has requested the reduction in services, they may sign a statement requesting the services be reduced. This request must be kept the individual’s record, and the reduction in service citation is not required.

Interim Care Plans

Interim care plans are limited to individuals who receive services though the HCBS Medicaid Waiver and require services immediately, or who are affected by a natural disaster or other emergency. An interim care plan may be developed for an individual who is on Medicaid, has an approved Level of Care (LOC) Determination that was completed within the previous 90 days, and the case manager is unable to complete an immediate visit. When services are needed immediately the case manager will need to complete a face-to-face visit and complete an assessment within 10 working days of the request. During natural disasters or other emergencies, a face- to- face visit must be made within 60 days of the request. Prior approval from the Department is required.

- Example 1: An individual who is currently in a Nursing Home, has a LOC in place, and is on Medicaid, plans to return home and the Case manager is unable to see the individual on the day of transfer home. An interim care plan could be written, and services could begin, however, a face-to-face visit would need to be completed within 10 days.
- Example 2: A current individual has a LOC in place, is on Medicaid but because of flooding their residence is not accessible, an interim care plan could be written so services could continue for up to 60 days before a face-to-face visit is required.

Medicaid eligibility redetermination is completed by Economic Assistance. An individual who is receiving service through the HCBS Waiver is required to be receiving Medicaid. If, in the redetermination process, it is determined the individual is not eligible for Medicaid, payment for services stops the day Medicaid terminates. If the individual has an established HCBS Care Plan and PreAuth and the termination is overturned, waiver services could be paid during that period of time.

4. Implementation/Review

The case manager's role during implementation is to educate others in the team about the possibilities of long-term services and supports, facilitating planning now and into the future, problem solving, coordinating integrated services and supports, conflict resolution and advocacy (CtLC, 2020). The case manager is responsible for assessing and authorizing services offered under Aging Services in addition to working collaboratively other formal and natural supports. It is important to understand the role of the case manager in relation to the other team members involved in the individual’s care. Open discussion surrounding the roles of the team members should be included in the care planning meeting and implementation planning process. It is helpful to clearly define the roles of each member and write a list of tasks that team members are responsible for in the implementation of the plan. The case manager is responsible for monitoring the plan for progress and any changes in the individual's care needs.

<u>Release of Information (ROI) Guidance for Implementation and Review of Person-Centered Planning</u>

It is best practice is to have a ROI signed by the individual and/or their legal representative whenever releasing information. A ROI provides proof that the individual agrees and understands what information is being released and the purpose of releasing the information. As a professional, with a professional license or certification, having an ROI on file, also provides guidance and assurance to the professional on the individual wishes to how and what information they have agreed to release to another entity.

Governing Policy; DHHS Confidentiality Manual

01-20. Disclosure of Client-Identifying Information (Revised 03/18 ML #3516)

01-20-01. Use Within the Department (Revised 03/18 ML #3516)

01-20-10. Disclosure Outside the Department (Revised 03/18 ML #3516)

01-25-45.01. Treatment, Payment, Health Care Operations (Revised 03/18 ML #3516)

Treatment: Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Treatment involves health services provided by a health care provider and tailored to the specific needs of an individual patient (not entire populations).

Activities are considered treatment only if delivered by a health care provider or a health care provider working with another party.

Activities of health plans are not considered to be treatment.

01-25-45-25. Disclosure of PHI to Business Associates (Revised 03/18 ML #3516)

<u>Continuity of Care</u>

In order to coordinate services for an individual, case managers may need to make referrals and gather other collateral information. Not all communication requires a release of information.

Examples, Questions and Answers

Case Managers can share individual information with health care professionals working in these following settings: Home Health Care, Hospitals, Clinics, PACE, and LTC facilities as this communication is part of the continuum of care guidelines under HIPAA. Case Managers can also share information with other case management entities (i.e. DD, VR, Behavioral Health) within the Department of Health and Human Services, as well as Eligibility Workers under the Medical Services Division. Information shared without a release of information must be on a need-to-know basis to coordinate care for the individual, disclosing only the minimum necessary amount of information pursuant to 45 CFR 164.502(b). Disclosure of information related to Psychological or Substance Abuse Treatment requires that the individual sign a Release of Information.

Question: Are there program federal and state rules and regulations that dictate what information can be disclosed?

Answer: HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, (with few exceptions), treats mental health information the same as other health information. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:

- medication prescription and monitoring
- counseling session start and stop times
- the modalities and frequencies of treatment furnished
- results of clinical tests
- summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

HIPAA generally **does not limit** disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. Covered entities should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.

Requests for records made by a covered entity to be delivered to another covered entity for care purposes are called "Continuity of Care" requests. **Records necessary for care of the patient fall under the "treatment" provision on the HIPAA Privacy Rule and do not require an authorization from the patient.**

Question: Are case managers able to release third party records (medical records that the CM may have on file from medical providers) to perspective providers such as AFC, ARS, or skilled nursing facilities?

When an HCBS client asks for assistance with admission into a nursing home or into an agency AFC, ARS, etc., the admitting agency may want medical records to review in order to make a determination for accepting the individual.

Example: An HCBS client is requesting SNF placement. The family isn't much help as they do not understand the paperwork and can't send the records needed. The individual family wants the CM to help with getting this individual admitted ASAP and the individual is in agreement. We are searching for nursing homes across the state, but each NH wants a history and physical, med list, therapy notes, all the medical information they can get to review the case and see if they can meet the individual needs. With an ROI signed, can HCBS send the requested third-party records to the potential provider?

Answer: Case Managers are able to release (provide) third party records to perspective providers, AFC, ARS or SNF to provide "Continuity of Care" to the individual served. This would include records such as the history and physical, medication list, physical or occupational therapy notes and other medical diagnosis or needs.

Case Manager are **NOT** able to release psychotherapy notes as they are protected information.

Further Guidance referenced from DHS Confidentiality Manual 01-25-35. Information Obtained from Sources Outside the Department (Revised 03/18 ML #3516) Information obtained from sources outside the Department, also known as "third party information" or "collateral information," does not enjoy any special status with regard to its use or transfer within the Department or disclosure outside the Department unless different treatment is specifically required by federal or state law, federal regulations, or state administrative rules.

Information, which does enjoy special status, includes Social Security records, Vocational Rehabilitation records, substance use disorder treatment information, adoption information, and the identity of a reporter of suspected child abuse or neglect.

The workforce member responsible for responding to requests for information (e.g., counselor, case worker, records custodian) has the duty to be aware of laws and regulations mandating different treatment, and to seek assistance if he or she has questions.

Question: For entities that we have contracts with who are not employed by the DHHS, do we need a release to coordinate services in addition to the contract that permits the disclosure of PHI? (This would include the Alzheimer's Association, CILS, MFP after a case close with MFP, the Senior Centers, etc.)

Answer: This depends.

1. Are there program federal and state rules and regulations that dictate when and how information can be disclosed?
2. Is there a business associate agreement in addition to the contract that permits the disclosure of PHI?

3. Is the disclosure for treatment purposes? Under the "Continuity of Care" law, it talks about info related to "care of the person" so we know we do not releases for HHC or the hospital, but these other entities are more of a gray area.

Due to this being a gray area, a ROI would be needed in most to release information to outside entities such as The Alzheimer's Association, CILS, MFP after a case closes with MFP, the Senior Centers, etc.

Collaboration and PHI Disclosure between LTC Ombudsman and Vulnerable Adult Protective Services (VAPS)

- Case manager disclosing the PHI of a LTC resident for the purpose of filing a complaint about a LTC facility with the LTC Ombudsman. Case managers are health care providers and are subject to HIPAA. HIPAA permits this disclosure.
- Case Manager disclosing the PHI of a LTC resident for the purpose of reporting abuse/neglect of a vulnerable adult to VAPS. Case managers are health care providers and are subject to HIPAA. HIPAA permits this disclosure and NDCC 50-25.2-03 requires the disclosure.
- Disclosure by VAPS of information of a LTC resident pursuant to an abuse/neglect report, to the LTC Ombudsman. Neither VAPS nor the LTC Ombudsman are subject to HIPAA. They may receive PHI from a case manager, but once they receive it, it is no longer PHI and is subject to the confidentiality of the VAPS and LTC Ombudsman state confidentiality laws. This disclosure of information from VAPS to the LTC Ombudsman is required under NDCC 50-25.2-04.

3. Implementing the Person-Centered Plan of Care - The Case Manager assures that services are implemented, and existing services continued as identified in the person-centered plan of care. This activity includes contacting the QSP and issuance of a Preauth.

4. Monitoring - Service monitoring is an important aspect of case management and involves the case manager's periodic review of the

quality and the quantity of services provided to service recipients. The Case Manager monitors the individual's progress/condition and the services provided to the individual. As monitoring reveals new information to the Case Manager regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case management entity is responsible to monitor the service plan and individual's health and welfare. If the individual's care needs cannot be met by the care plan and health, welfare, and safety requirements cannot be assured, case management must initiate applicable changes or request a team staff meeting through the HCBS Program Administrator to discuss possible terminate termination of services. If the case is closed, the individual is made aware of their appeal rights (see Closures, Denials, Terminations, and Reductions in Services 525-05). The case manager shall document all service monitoring activities and findings in the individual's case file.

1. The HCBS Case Manager must contact the individual after the first 30 days from the initial care plan implementation. This may be via phone or face-to-face. (If the individual is unable to communicate via telephone, a face-to-face visit is required.) The purpose of this contact is to follow up on the implementation of the person-centered plan of care (PCP), ensure the individual's needs are met and ensure the scope and amount of services authorized are provided.

2. The HCBS case manager shall monitor the services provided under the PCP on an as needed basis but not less than direct individual contact at least once every three months for Medicaid Waiver, MSP level B and MSP level C.

3. Residents of basic care facilities under Basic Care Assistance Program must have an initial and annual HCBS Comprehensive Assessment and completion of the SFN 662.

4. Monitoring contacts and reassessments may be required if there is a change in the individual's condition or critical incident report (CIR) that requires a follow up to ensure health and safety of the individual.

5. Monitoring for Abuse, Neglect, or Exploitation: When completing monitoring tasks, if the case manager suspects a Qualified Service Provider or other individual is abusing, neglecting, or exploiting a recipient of HCBS, the following protocol is to be followed by the HCBS Case Manager:

In all situations:

1. Initiate a formal VAPS (Vulnerable Adult Protective Services) referral according to ND Century Code 50-25.2-03(4).

   REPORTING OPTIONS

   - Online https://bit.ly/3vbYbEj
   - Reporting Form, SFN 1607 sfn01607.pdf (nd.gov) can be emailed to: dhsvaps@nd.gov or faxed to: 701-328-8744

2. Notify the HCBS Program Administrator responsible for complaint resolution in writing of **all actions** taken to follow up on a suspected case of abuse, neglect, or exploitation of an HCBS recipient.

3. The Risk Assessment and Health and Safety Plan may need to be updated and reviewed in the following circumstances.

   - When there is a risk identified during assessment, reassessment or monitoring visits.
   - Critical incident report (CIR) has identified a risk to the individual served by HCBS.
     - The Program Administrator responsible for monitoring and review of all CIR's will contact the case manager in the event there is an event reported that requires an update to the Risk Assessment and Health and Safety Plan.
   - QSP complaint has identified a risk to the individual served by HCBS.
     - The Program Administrator for monitoring and review of all QSP Complaints will contact the case manager in the event that there is a complaint that requires an update to the Risk Assessment and Health and Safety Plan.

- VAPS report has identified a risk to the individual served by HCBS.
    - VAPS and HCBS case manager will work together to update or revise the Risk Assessment and Health and Safety Plan to address any identified risk or health and safety concerns identified in the VAPS report.

Documentation for an event involving abuse, neglect, exploitation, CIR, QSP complaint or VAPS must be included in the case note and include the following:

- Identify and document in writing the name of the qualified service provider or other individual provider.
- Document in writing a complete description of the problem or complaint.

Process:

- Immediately report suspected physical abuse or criminal activity to law enforcement.
- If you have reasonable grounds to believe the recipient's health or safety is at immediate risk of harm, make a home visit to further assess the situation and take whatever action is appropriate to protect the recipient.
- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the HCBS Case Manager and Nurse Educator determine that an incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately report the critical incident to the Department.
- Comply with North Dakota State law Chapter 50-25.1, CHILD ABUSE AND NEGLECT.

- When the service is provided on Reservation Lands, the Tribal Laws that govern abuse and neglect on that reservation must be followed.

Process specific to the individual's living arrangements, individuals implicated, or the Provider type (all incidents/actions must be reported to the Aging Services Program Administrator):

- Individual lives in his or her own home and the qualified service provider is an Individual or Agency enrolled QSP:

  If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.

- If the provider is a Basic Care Facility or Residential Care Facility that is licensed as a Basic Care Facility:

  Notify the Ombudsman Program Administrator, Aging Services Division

  And

  The North Dakota Department of Health Facilities.

- If the qualified service provider is an Assisted Living Facility:

  Notify the Ombudsman Program Administrator, Aging Services Division

  And

  The DHS Program Administrator responsible for Assisted Living Licensing.

- If the complaint involves the provision of home delivered meals, contact the HCBS Program Administrator.

- Individual lives in his or her own home and is being abused, exploited, or neglected by an individual other than the QSP:

File a report with law enforcement and/or Adult Protective Services as indicated by the seriousness of the allegation.

- If the individual is living in an AFC Home:

  Contact the HCBS Case Manager responsible for AFC licensing,

  And

  Contact the Aging Services Division Program Administrator.

- If the case involves a Licensed Child Foster Care Home, the regional representative responsible for the children's foster care licensing must be contacted.

- If the case involves an individual who is receiving DD Services, contact the individual's DD Program Manager or the Regional Program Administrator.

The Department of Human Services may remove a Qualified Service Provider from the list of approved providers if the seriousness and nature of the complaint warrants such action. The Department will terminate the provider agreement with a Qualified Service Provider who performs substandard care, fraudulent billing practices, abuse, neglect, or exploitation of a recipient. North Dakota Administrative Code section 75-03-23-08 lists reasons why the Department may terminate a Qualified Service Provider.

5. Reassessing - The case manager reassesses the individual, care plan, and services on an ongoing basis, but must do a reassessment at six-month intervals and the comprehensive assessment annually. At the six month and annual visit, the individual stated goal must be reviewed, and progress or continuation of the goal must be noted in the narrative of the vision tool.

6. Termination of Service - When documenting that service(s) on the Individual Care Plan or the Person-Centered Plan of Care were terminated, and indicating the reason(s) for termination, refer to Closures, Denials, Terminations, and Reductions in Services (525-05-40) unless the individual is requesting services to be reduced. In situations where the individual has requested the reduction in services, they may sign a statement requesting the services be reduced.

Contacts with Individuals

Virtual Supports -

A visit by virtual means can be conducted when individual cannot have an in-person face to face due to extenuating circumstances. The individual may be afforded the option to use the phone or other telehealth technology to engage in the development and/or monitoring of person-centered plans when there are extenuating circumstances impeding the ability to conduct the visit in person.

- Extenuating circumstances may include instances where the in-person visit poses a health or safety risk to the individual or case manager; public emergency as determined by local, state and federal government.
    - Examples of extenuating circumstances may include but are not limited to the following instances:
        - The individual cannot be seen due to having a medical condition, ie., contagious disease, treatments that weaken the immune system,
        - Natural disasters and or threats,
        - Weather related road closures, no- travel advisories.
- The participant's services may not be delivered via virtual support 100% of the time.
- The participant must always have the option to request in-person services.
- Instances of visit by virtual mean must be approved by the HCBS CM Supervisor or HCBS Program Administration as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion.
- Virtual supports are not a system to provide surveillance or for staff convenience.
- Any issues will be addressed prior to the implementation of remote supports and documented in the individual's case record.
- In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant's dignity and privacy is not permitted. Provider must use a HIPAA compliant service delivery method.

- (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider.

Once the extenuating circumstance no longer limits the ability to complete the home visit, the case manager must follow-up with a face-to-face visit for monitoring as outlined in policy.

- The face to face must be scheduled as soon as possible, not waiting until the next required visit.
- The required face to face visits provides assurance that the individual is receiving services within the scope and amount authorized.
- The face to face also assures a view of possible health, welfare and safety concerns that may not be relayed through the phone or virtual contact.

<u>For SPED and EXSPED -</u>

- An Initial HCBS Comprehensive Assessment is required to establish eligibility for services and following implementation of the service a contact shall be made with a NEW individual within the first 30 days of implementation of services. The initial, annual assessment and six-month assessment are required to be face-to-face visits in the individual's home. During the annual and six-month assessments a quality review questionnaire is completed with the individual as part of the assessment process.

<u>Waiver:</u>

- HCBS Waiver Services: An Initial HCBS Comprehensive Assessment is required to establish eligibility for services. Following implementation of the service, a contact (either in person or via telephone) must be made with a NEW individual within the first 30 days of implementation of services. Quarterly contacts with the individual are required, including an annual assessment, six-month reassessment and two quarter contacts. During the annual and six-month assessments, a quality review questionnaire is completed with the individual. **All four contacts must be face to face and take place in the individual residence.**

- Case Management coordinates an annual interdisciplinary team conference and invites the legal representative and others as requested by the individual.

All required contacts must include responses to the following questions:

- Date
- Reason for contact. (initial, annual, six month, quarterly, collateral, returned call, received call, etc.)
- Location of visit (home visit, care conference, hospital visit, office visit, telephone contact, letter sent, etc.)
- A description of the exchange between yourself and the individual or the collateral contact. If this is a face to face visit- describe the environment, individual's appearance, and communication style
- Review the Individual Service Plan developed by the Adult Residential Provider (who provides services primarily to individual with TBI) or the Transitional Care Provider at the annual and semi-annual interdisciplinary team meeting and document the results of the Individual Program Plan
- Individual satisfaction
- Follow-up plan

Level of Care Determination (LOC)

It is the responsibility of the HCBS case manager to initiate the screening either by submitting information to Maximus.

A LOC determination/screening must be completed for an individual who is requesting services through a waiver program, or an individual who under the age of 18 and requesting SPED services, and MSP-PC Level B or C. LOC determinations must be updated as significant changes occur that would impact the LOC determination outcome and at minimum on an annual basis. Following are the screen types listed on the LOC Determination Form.

- HCBS Waiver
- MSP-PC (Level B or C)
- SPED under age 18

- MSP-PC/SPED under age 18 (Check only if eligible for both)

For the purposes of opening/re-opening or prematurely closing a HCBS screening, see the instruction for the SFN 474.

No screening will be needed if Waiver Services are re-implemented within 90 days of the individual's discharge from the nursing home or swing bed and prior to end date of the LOC of the current HCBS screening.

- The reopening date of the LOC for HCBS Waiver must be indicated on the SFN 474.

Upon completion of LOC determination, Maximus will submit to the Aging Services Division a list of the recipients, with the approval or effective date of eligibility, ID Number, and date of birth. This information will then be entered on the Nursing Home Eligibility file in the payment system. DDM will also send written confirmation of HCBS (NF) determination to the HCBS case manager for filing in the individual's record.

When an HCBS individual screened for Medicaid Waiver services appears to no longer meet nursing facility (NF) care (Screen Type: HCBS), a re-screening should occur. A significant improvement in the recipient's medical/physical status or a decrease or cessation of services provided are examples that could trigger a re-screening. Maximus needs to be informed of the reason for the screening and intended outcome to "other". If Maximus concurs the recipient no longer needs NF care, an ending date of services needs to be given to Aging Services by using the SFN 474, to Aging Services/HCBS. The ending date is the responsibility of the case manager and needs to allow sufficient time in which to give the individual a ten-day (calendar days) notice of service termination under the Medicaid Waiver funding source. Maximus will report screening terminations with closing dates to Aging Services. Aging Services will input the ending date of services on the computerized screening.

<u>Nursing Facility (HCBS) Level of Care Determination But The Individual Is Not Receiving Waiver Services</u>

The stop date on the screening is important for Medicaid recipients having a spouse in the household who qualify for spousal impoverishment. The recipient is treated, for Medicaid budgeting purposes, as if living in the nursing facility only when RECEIVING services paid by the Waiver. If an individual is residing in their home, receiving spousal impoverishment under Medicaid, they must receive a Medicaid Waiver service each month to remain eligible under the spousal impoverishment guidelines. If Waiver funded services are NOT provided, the screening must be "closed" so that

the correct budgeting method is reflected in the Medicaid data system. Submit SFN 474, HCBS Case Closure/Transfer Notice, so a closing date is entered in the Medicaid data system.

Case File Contents

1. For all programs, all case files, or in the web-based case management system should have (at a minimum):
    a. Application for Service SFN 1047
    b. A signed copy of Your Rights and Responsibilities brochure (DN 46)
    c. Preauth for Medicaid Waiver, SPED/Ex-SPED, and MSP (updated every six months)
    d. Monthly Rate Worksheet (if applicable)(SFN 1012 updated annually)
    e. HCBS Notice of Denial or Termination SFN 1647 (if applicable)
    f. HCBS Case Closure/Provider Termination SFN 474 (if applicable)
    g. An end dated or deleted Preauth (if applicable)
2. The case file for each Medicaid Waiver individual must contain:
    a. Documentation of verification the person is a Medicaid recipient
    b. Medical information (if applicable)
    c. Record of current level-of-care determination(s) (updated annually)
3. The case file for each Expanded SPED individual must contain:
    a. Expanded SPED Program Pool Data SFN 56
    b. Add New Record to MMIS Eligibility File, SPED and ExSPED, SFN 676
4. The case file for each SPED individual must contain the:
    a. SPED Program Pool Data SFN 1820
    b. Add New Record to MMIS Eligibility, SPED and ExSPED, SFN 676
    c. SPED Income and Asset SFN 820, (updated annually)

Claiming for Case Management

Effective 1/1/2025:

1. HCBS Case Management is provided by state employed HCBS Case Managers.

2. The state administratively claims for the service of HCBS Case Management for Targeted Case Management for Medicaid State Plan and HCBS Waiver Case Management.
    a. HCBS Case Management activity for Medicaid waiver and Medicaid State Plan-Personal Care, Targeted Case Management, is tracked by HHS for the purpose of administratively claiming.
        i. Case managers are required to track their time in the state time record system on a daily basis.
    b. The state may claim for case management if the individual meets the eligibility criteria of the programs as identified in HCBS Case Management - Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities.

        Such activities include:

        i. Assisting individuals in accessing and receiving Home and Community Base Services
        ii. Completion of the HCBS comprehensive assessment
        iii. Level of care screening
        iv. Person-centered planning
        v. including care plan development, assessment, monitoring, and completing the plan
        vi. Monitoring
        vii. Reassessment
        viii. Implementation of the person-centered plan
        ix. including assisting the eligible individual to explore and understand options, make informed choices, solve problems, provide a link between community resources, and qualified service providers, and closure and termination of services
    c. HCBS Case Management time must be supported by documentation in the individual's case file and/or web-based case management system that case management service activities were completed.
    d. The state will administratively claim for case management services for individuals working towards transition when the individual leaves the institutional setting and enters the waiver program.

i. Time tracking for individuals working towards transition is categorized as administrative time while the individual is institutionalized. Once the individual has transitioned to the community, case management will be tracked based on the funding source of the HCBS services authorized by case management.

3. HCBS Case Management for **SPED and EXSPED are non-billable**
   a. The state must not administratively claim for the time spent working on allowable case management task that involve SPED or Ex-SPED even if that person is a Medicaid recipient.
   b. Case Management time is documented in 15-minute increments in the states time tracking system under EXSPED, SPED.
4. HCBS Case Management costs are no longer applied to individual cost share or recipient liability.
   a. Case Management billing provided prior to 1/1/2025 may apply to the individual cost or cost share.
   b. Balances owed for services prior to 1/1/2025 still apply.

When providing case management on a new referral for a Medicaid recipient, time tracking would be categorized as MSP, XIX Medicaid as assisting individuals in accessing and receiving Home and Community Base Services.

When a change in funding source occurs, from state funded programming to Medicaid funded programming, Case Management time can be administratively claimed for the following activities for HCBS Medicaid Waiver and MSP:

- Assisting individuals in accessing and receiving Home and Community Base Services
- Completion of the HCBS comprehensive assessment,
- Level of care screening,
- Person-centered planning,
  - including care plan development, assessment, monitoring, and completing the plan,
- Monitoring,
- Reassessment,
- Implementation of the person-centered plan
  - including assisting the eligible individual to explore and understand options, make informed choices,

solve problems, provide a link between community resources and qualified service providers, and closure and termination of services.

5. Administrative Tasks (Non-billable) Administrative tasks such as those listed below are examples of non-billable activities:
    - Assisting a provider with billing issues or enrollment; participating in appeal hearings; attending training or staff meetings; supervising/scheduling of In-home Care Specialists, etc.
    - Travel
    - Leave

Adult Day Care 525-05-30-10

(Revised ~~11/1/21~~ 6/1/2025 ML #~~3640~~3921)

Purpose

Adult Day Care is a community-based service offered within a group setting designed to meet the needs of functionally impaired adults. It is a structured, comprehensive service that provides a variety of social and related support services in a protective setting during a part of the day. Adult Day care programs shall operate a minimum of three hours per day up to a maximum of ten hours per day. Individuals who participate in Adult Day Care attend on a planned basis during specified hours. Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring for an impaired member at home.

Adult Day Care emphasizes a flexible program of service activities designed to provide an individualized plan of care. It affords opportunities of personal enrichment and provides a setting for group involvements outside the home. Adult Day Care reduces isolation often associated with frailty and impairment as well as enabling the individual to remain in his or her home and community as long as possible.

Service Eligibility, Criteria for

The individual receiving Adult Day Care will meet the following criteria:

1. Must be eligible for the programs of Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.

2. The individual is able to function in an ambulatory care setting.

3. The individual is able to participate in group activities.

4. The individual requires assistance in Activities of Daily Living and Instrumental Activities of Daily Living as determined by the Comprehensive Assessment.

5. When the individual is not living alone, the primary caregiver will benefit from the temporary relief of caregiving.

Service Activities, Authorized

The service tasks/activities within the scope of this service chapter are identified on the authorization.

Unallowable Service Activities: Shopping, Housework, and Laundry are tasks which are not authorized under Adult Day Care Services.

- Nonmedical transportation may be included as a part of this service and may already be included in the rate, contact a HCBS Program Administrator to determine if nonmedical transportation has been included the rate for an Adult Day Care Provider.
- Adult Day Care ~~Unit – one unit equal 1/2 day.~~ Rate – Rate is established depending on the hours of care received.

Adult Day Care Enrollment (Provider)

Staff to Participant Ratio for Adult Day Care Programs ~~Centers~~

1. Adult Day Care Program ~~Centers~~ providers shall meet a staff to participant ratio not to exceed a minimum of one to eight.

2. Full-time or full-time equivalent staff shall be considered as those who spend 70 percent of time in direct service with participants.

3. Each adult day care center that is conjointly located within another facility may consider a shared staffing arrangement, however, shared staff must meet specific adult day care staff standards.

Adult Day Care 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.**

Facility Standards for Adult Day Care Programs ~~Centers~~

1. Adult Day Care in Hospitals, Nursing Homes, and Basic Care Facilities

   - Hospitals, nursing homes, and basic care settings ~~facilities~~ are considered to have met the standards contained in this section based upon their licensure status.

   - 1915(c) Medicaid waiver funds cannot be used to provide adult day care that is located in a nursing home or hospital. Waiver recipients are not eligible to receive an HCBS service in an institutional setting regardless of the funding source. SPED & Ex-SPED recipients may receive adult day services in these settings.

2. Adult Day Care Programs ~~Centers~~

   Adult day care program settings ~~center facilities~~ shall meet the following standards:

   1. The setting ~~facility~~ shall be designed and furnished with primary consideration given for the special needs and interests of the population to be served and the activities and services to be provided.

      - A setting ~~facility~~ shall be architecturally designed, in conformance with the requirements of Section 504 of the Rehabilitation Act of 1973, to accommodate handicapped individuals and meet any state and local barrier-free requirements.
      - Illumination levels in all areas shall be adequate, and careful attention shall be given to avoiding glare in order

to compensate for visual losses experienced by many older adults.

- Sound transmission shall be controlled. Methods of sound control include acoustical ceiling surfaces, partitions between activity areas, separation of noisy rooms such as the kitchen, etc.
- Heating, cooling and ventilation system(s) shall permit comfortable conditions, regardless of the number of participants present, and excessive fan noise and drafts shall be avoided.
- The design shall facilitate the participants' movement throughout the center and involvement in activities and services.
- Sufficient furniture shall be available to accommodate the number of enrolled adult day care service participants.
- Furniture and equipment to be used by participants shall be selected for comfort and safety. Furnishings shall promote independence as much as possible and be appropriate for use by persons with visual and mobility limitations and other physical disabilities.
- A telephone shall be available for participant use.

b. The setting ~~facility~~ shall be accessible at street level. Adequate elevators shall be available for center floors not located on street level.

- Each adult day care setting ~~center~~, where it is collocated in a facility housing other services, shall have its own separate identifiable space. (The allocation of separate identifiable space is necessary to be able to properly accommodate the number of enrolled day care participants.)
- The setting ~~facility~~ shall:

  - Have at least thirty-five (35) square feet of program space for each day care participant. (The square footage excludes hallways, offices, restrooms and storage areas.)
  - Be flexible and adaptable for large and small groups and individual activities and services.
  - The setting ~~facility~~ shall include toilets for male and female participants (at least one toilet per gender for each fifteen participants), equipped for use by

mobility-limited persons and easily accessible from all program areas.
- At least one restroom with a lockable door/stall is available to recipients to assure recipients privacy.
- Have rest areas designated to permit privacy and to isolate participants who become ill.
- A parking area shall be available for the safe daily arrival and departure of participants.
- Space shall be available for outdoor activities, when appropriate.
- Space, such as closets and separate lockers, for outer garments and private possessions shall be provided for participants.

c. The setting ~~facility~~ and grounds shall be safe, clean and accessible to all participants.

- The setting ~~facility~~ shall be designed, constructed and maintained in compliance with all applicable local, state and Federal health and safety regulations. The setting ~~facility~~ shall make arrangements as necessary for the security of the participants in the setting ~~facility~~.

  - Appropriate and locked storage space for medications shall be provided.
  - At least two well-identified exits to the outside shall be available.
  - Non-slip surfaces or carpets shall be provided on stairs, ramps and interior floors.
  - Outside lighting shall be available at the setting ~~facility~~ entrances and on the setting ~~facility~~ grounds.
  - The setting ~~facility~~ shall be free of hazards, such high steps, steep grades, exposed electrical cords, etc. (When necessary, arrangements shall be made with local authorities to provide safety zones for those arriving by motor vehicle and adequate traffic signals for pedestrian crossings.)

- Safe and sanitary handling, storing, preparation and serving of food shall be assured.
- Procedures for fire safety shall be adopted and posted, including provisions for fire drills, inspection and maintenance of fire extinguishers.

- A representative of the local fire department or State Fire Marshal's office shall conduct a fire and safety inspection of the Adult Day Care setting ~~Center~~ prior to the center being approved for adult day care services. Regular inspections shall be scheduled once every two years thereafter.
- Emergency first aid kits shall be visible and accessible.
- Written center policies shall be established on:
    - Assisting adult day care participants in the self-administrator of medications; and
    - For emergency medical care plans.
- Maintenance and housekeeping shall be carried out on a regular schedule and in conformity with generally accepted standards, without interfering with the program.

Standards for Adult Day Care Homes

1. Adult foster care homes which are licensed by the Department of Health & Human Services are considered to have met the Adult Day Care standards contained in this section based upon their licensure status.

2. Adult Day Care Homes

   Adult Day Care Home setting ~~facilities~~ shall meet the following standards:

   a. The home and premises must be clean, neat, and free from hazards that jeopardize health and safety.

   b. A rest area shall be provided separate from activity areas.

   c. The phone numbers of the local police, fire department, and ambulance service shall be posted near every telephone located in areas where services are provided.

   d. Safe storage for medications shall be provided in a central location with each participant's medication clearly labeled with the pharmacist's label.

e. The home must be equipped with adequate light, heat, ventilation, and plumbing for safe and comfortable occupancy.

f. All participant-occupied rooms shall have window screens which will keep out flies and mosquitoes.

g. Food and cooking utensils shall be stored to protect from dust, leakage from pipes, or other contamination.

h. Trash and garbage outside of participant occupied areas shall be kept in plastic or metal containers with properly fitted covers and disposed of on a daily basis.

i. A community or rural fire department shall be available to the home.

j. There shall be no accumulation of highly combustible material in closets, attics, basements, garages or other parts of the dwelling unit.

k. Fireplaces, steam radiators, and hot surfaces, such as steam pipes, shall be appropriately screened or covered to guard against accidental contact. Space heaters may not be utilized.

l. Participant occupied areas shall have at least two means of exit, each being at least 30 inches wide, at least one of which shall be a door providing a means of unobstructed travel to the outside of the building at street or ground level.

m. Heating units shall be inspected prior to the time adult day care service is provided in the home and every two years thereafter. A notice shall be posted on or near the heating unit indicating the last date of inspection.

n. No stove or combustion heater shall be so located as to block escape in case of fire caused from malfunctioning of the stove or heater.

o. At a minimum, a five-pound class "ABC" all purpose fire-extinguisher shall be maintained and installed in a location identified by the local fire department. Additional fire extinguishers may be required when warranted by special conditions.

p. Every adult day care home shall have photo-electric or ionization type smoke detectors which shall be:

- Mounted adjacent to rest areas and shall be located on or near the ceiling;
- Clearly audible in adjacent participant occupied areas with intervening doors closed;
- U.L. approved; and
- In working order at all times.

q. All participants shall be trained upon enrollment on how to exit from the home and how to respond to alarm.

r. If the home has a fireplace or auxiliary free-standing heating unit, it must be properly installed and maintained. It shall be inspected and approved by the local fire department or State Fire Marshal.

s. A representative of a local fire department or State Fire Marshal's Office shall conduct a fire and safety inspection of the adult day care home prior to the home being approved for adult day care services. Regular inspections shall be scheduled once every three years thereafter. Additional inspections of the home may be requested at any time there are concerns about fire safety aspects of the home.

t. All dangerous household products, flammable liquids and chemicals shall be stored in a safe manner. Questions as to "safe manner" may be referred to the local fire department.

u. The use of potentially hazardous materials and tools by a participant shall be supervised.

v. Exposed light bulbs shall not be used in the immediate area any participant uses.

w. The fuses in light circuits shall not exceed recommended amperes. Type "S" fuses are recommended, or there shall be a safeguard of approved circuit breakers.

x. House pets shall have all required shots.

y. Existing state or local building, fire, or safety codes supersede any of the requirements of this section.

z. At least one restroom with a lockable door/stall is available to recipients to assure recipient privacy.

Program Standards for Adult Day Care settings ~~Centers~~ and Adult Day Care Homes

Adult Day Care settings ~~Centers~~ and Home service programs shall meet the following standards:

1. Self- Care Activities: The adult day care program will provide assistance with activities of daily living. Changes in the participant's status shall be noted in the participant's file and appropriate others notified.

2. Social, Leisure, and Educational Activities: Planned individual and group activities, suited to the needs and abilities of the participants as supported by the HCBS comprehensive assessment shall be provided. recipients may not be required to participate in any activity.

3. Nutrition:

    1. A nutritious meal including the basic four food groups shall be provided to each participant in attendance during mealtime.

    2. Meals shall be prepared and served in a sanitary manner using safe food handling techniques.

    3. A nutritious mid-morning and mid-afternoon snack shall be offered daily to participants. Recipients must have access to food/ snack at all times.

    4. Fluids shall be available as needed by participants.

    5. A modified diet shall be available for participants requiring a restricted diet. A registered dietitian or nutritionist may be consulted by the provider on special nutritional needs.

Emergencies: Adult Day Care settings ~~Centers~~ /Homes

A written procedure for handling emergencies shall be posted in the settingfacility. To respond to emergencies:

1. The participant's file shall include a written agreement with the participant or family regarding arrangements for emergency care and ambulance transportation.

2. A conspicuously displayed notice shall indicate fire procedures plus signs designating emergency evacuation routes; regularly (2 times annually) scheduled fire drills shall be conducted at the center; staff and volunteers shall be trained in evacuation procedures.

3. Training shall be provided for program staff and participants in emergency procedures.

Standards for Issuance to Adult Day Care Providers

The HCBS Program Administrator HCBS Case Manager shall provide the following information to potential adult day care service providers:

1. Community-Based Services: Qualified Service Provider Handbook.

2. Adult Day Care Standards Compliance Checklist (SFN 1703).

3. Adult Day Care settings Centers: Adult Day Care Facility Standards.

4. Adult Day Care Homes: Standards

The potential adult day care center or adult day care home service provider will complete and submit a self-administered Adult Day Care Standards Compliance Checklist, SFN 1703, together with evidence of any required inspections (fire and safety) to the HCBS Program Administrator.

By completing and submitting the Adult Day Care Standards Compliance Checklist, SFN 1703, the adult day care provider is notifying the HCBS Program Administrator that they are ready to have the HCBS Case Manager review their compliance with adult day care standards.

The HCBS Case Manager shall then make an on-site visit to the home or center and verify the compliance with adult day care standards and forward a copy of the final SFN 1703 to the HCBS Program Administrator.

Re-Assessment of Adult Day Care Standards for Compliance

The Adult Day Care Standards Compliance Checklist, SFN 1703, is valid for not more than two years from the date of issuance. If a provider chooses to continue to provide adult day care, the HCBS Case Manager must review all components of the Adult Day Care Program for compliance and complete the Adult Day Care Standards Compliance Checklist, SFN 1703. A copy should be forwarded to the HCBS Program Administrator.

Adult Day Care Recipient Experience Requirements

Individuals have freedom and support to control their schedules at the setting and are not required to participate in activities and have access to food/snack at any time.

Any modifications of the recipient experience requirements must be supported by specific assessed need: justified and documented in the person-centered service plan.

Community Support Services 525-05-30-21

(Revised 0~~2~~6/01/2025 ML #~~3899~~3921)

Definition

Community supports is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Community Supports may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

The participant must be able to benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation.

This service may be most beneficial to individuals with physical disability or complex medical needs who require ongoing custodial and/or maintenance care.

Purpose

Community Support Services provides all-inclusive service provided up to 24 hours a day to individuals who otherwise would be in an institutional setting.

Service Eligibility

The individual receiving Community Support Services will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Services.

2. Requires some level of on-going daily support.

3. The individual is capable of directing their own care or has a legally responsible party to act on the recipient's behalf.

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

Service Tasks/Activities

Care coordination is the primary responsibility of the QSP Agency Program coordinator. Authorized task includes:

1. Individual program Plan (IPP) Development, Coordination, Implementation and Evaluation.

    a. Complete tasks such as individual plan development, monitoring the plan and observing to assure that the

agency staff are trained, and the program is implemented, assisting with the development of behavior support techniques, assuring appropriate permission and approval is received from the individual and/or the legal decision maker.

b. Professional services are included in the "care coordination" hours and are not to be included in determination of direct support service hours.

Care coordination functions provided by the QSP agency include:

1. Management of an individual's property and resources including household budgeting, money management, communicating with creditors and landlords, etc.,

2. Application for generic services, monitoring status of those services, and maintaining communication with families, guardians, and other involved persons and agencies,

3. Coordinating medical needs,

4. Designing and implementing programs to enhance self-direction, independent living skills, community integration, social, recreational, and leisure skills and opportunities, and behavior management,

5. Facilitating the IPP planning process,

6. Assessing effectiveness of personal independence development strategies and other support services through analysis of information, consultation with the individual and/or guardian and family members, and observation of the person's programs and service settings,

7. Asserting and safeguarding the individual's human and civil rights, and

8. Attending to psychosocial needs of the individual.

Hours for direct staff time for personal supports include:

1. General supervision for safety and health monitoring and maintenance,
   a. If the individual is authorized for 24 hour 1:1 support, the QSP agency must ensure staff are present at all times. If the individual is able to be left alone for brief periods of time, this

information must be specified in the person-centered service plan and the IPP.

2. Homemaking which may include home maintenance,
3. Assistance with activities of daily living and instrumental activities of daily living
    a. bathing
    b. communication
    c. dressing/undress
    d. eyecare
    e. feeding/eating
    f. haircare/shaving
    g. housework
    h. incontinence
    i. laundry
    j. meal preparation
    k. mobility (inside/outside)
    l. Money Management
    m. nailcare (fingernails)
    n. shopping
    o. skincare
    p. teeth/mouth care
    q. toileting
    r. transferring/turning/positioning
4. Global Endorsements tasks

a. exercises

b. hoyer lift/mechanized bath chairs

c. indwelling catheter

d. medical gases

e. prothesis, orthotics

f. suppository, bowel program

g. TED socks

h. vitals

5. Client specific endorsements

a. apnea monitor

b. JOBST stockings

c. ostomy care

d. postural/bronchial drainage

e. RIK bed care

6. Medication administration

a. Under this chapter employees of an enrolled community support services QSP agency who have received Department approved training may administer routine medications to recipients even if they are unable to self-direct their care. The QSP agency must employ or contract with a licensed registered nurse who provides supervision to the employees who are administering routine medications. The licensed nurse determines competency in medication administration by the employee's successful completion of the Department approved medication practicum. This does not include medications administered through a parenteral route (e.g. intravenous or intramuscular injections). The licensed nurse is responsible for ensuring that medications have been administered correctly according to the six rights of

medication administration (individual, dose, time, route, medication, documentation), and that documentation is completed accurately.

b. The QSP agency must have a training protocol and policy established for the administration of all medications, including PRN medications. The registered nurse is responsible for the training and oversite of all medication administration.

c. The licensed registered nurse employed by the QSP agency may perform medication set-up.

7. Transportation to support medical, social, and essential community services.

8. Accompanying individual to medical appointments.

Hours for direct staff time for personal independence development:

1. Development of natural supports,

2. Activities and strategies to promote community inclusion/integration, leisure skill development, including activities to facilitate socialization and recreation that are tied to a therapeutic goal, and

3. Support and adaptive strategies to enhance the person's control and independence over environment, resources, activities, and self-care.

<u>Authorization for Services</u>

1. The service tasks/activities within the scope of this service chapter must be identified in the assessment and on the Preauth.

2. An Individual Program Plan (IPP) as outlined in the Community Supports provider standards must be developed by the authorized QSP agency and maintained in the individual’s file. An IPP is an individualized plan that describes the goals, wants, needs, and strengths of the person. It describes in detail how the QSP agency is supporting the individual.

a. Service task and activities must be tied to an individual's goals as determined through the person-centered planning process.

b. The IPP must correlate with the person-centered plan and services authorization that is completed by the HCBS Case Manager.

c. The IPP must be developed by the QSP Agency Program Coordinator within the first 30 days of service provision and forwarded to the case manager and every 6 months thereafter.

d. The IPP must be approved by the state program administrator.

e. The IPP must include:

   i. A plan for promotion of the individual’s independence in ADLs and IADLs, social, behavioral, and adaptive skills,
   ii. Tasks being provided which should match the authorization provided by the HCBS case manager,
   iii. A medication list if medication administration is authorized and description of how medications are being managed;
   iv. Medical diagnoses;
   v. A therapeutic goal for community integration activities which would include companionship and socialization activities. The individual should be involved in goal setting and ideas for these activities;
   vi. Temporary absences and requests for retainer payments. Including any requests for retainer payments and dates of absences submitted to HCBS Program Administration for retainer payment authorization.
      - Note: Retainer payments cannot exceed 30 days per calendar year.
   vii. Signature of the agency care coordinator and date.

Reasonable Modification:

To comply with Title II of the ADA, a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. Refer to: Requests for Reasonable Modification 525-05-55.

This service may include nursing care to the extent permitted by state law under NDCC 43-12.1 and NDAC 54-05, which will maintain the health and well-being of the individual and allow the individual to remain in the community. Approval of tasks medical in nature under Community Support services are services that an individual without a functional disability would customarily and personally perform without the assistance of a licensed health care provider, such as administration of medications, or wound care.

If a modification is approved under the Community Support Program to complete tasks that are medical in nature and that are specific to the needs of an eligible individual, a Registered Nurse (RN) must complete an assessment to determine if the tasks will be completed by the RN or trained to the QSP agency staff. If a necessary medical task is too complex to be taught to the QSP agency staff, the nurse may provide the service directly to the individual.

The QSP agency must submit:

1. Agency policy specific to the medical task being completed
2. Evidence of training of the QSP agency staff by the RN using the **SFN 585**.
3. Example of how they will document these tasks
    a. Nursing task documentation should align with the professional nursing documentation requirements/standards to ensure accuracy and consistency.
4. A copy of the IPP to include an explanation of tasks that will be delegated, tasks performed by the nurse, and how the nurse will provide an oversight of these tasks. The **SFN 585** along with the IPP is required initially within the first **48 hours** of services beginning, every 6 months, and annually. If there are medical tasks being performed, the RN must sign and date the IPP along with the Care Coordinator.

Allowable Service Combinations

Chore, ERS, Environmental Modification, Adult Day Care, Supported Employment, Extended Personal Care includes Nurse Education, Home Delivered Meals, Transition Coordination, and/or Specialized Equipment.

Limits

Community Support Services may not be authorized with Respite Care, Homemaker, Adult Foster Care, Family Home Care, Personal Care, Family Personal Care, Adult Residential, Transitional Living, Attendant Care, Supervision, Companionship, Community Support Services and Non-Medical Transportation. For unusual or unique circumstances, contact the Aging Services Program Administrator for approval consideration.

1. This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.

2. Supervision may not be authorized in excess of what is necessary for health and safety.

    a. For example, the family is requesting that someone stay with their relative 24 hours a day when there is not a safety or health risk other than the possibility that something might happen.

    b. Supervision may not be used to restrict an individual from alcohol or substance use.

3. Twenty-four hour supervision in a shared living environment- Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the individual or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.

    a. A 'safety threat' means the individual is so aggressive, self-destructive, or requires such close supervision that any attempt to share one on one staff at any time will place the individual at immediate risk.

    b. Shared tasks will be considered in a shared living environment, and may affect the daily rate for these services (e.g. housekeeping of common areas, shared meals preparation, and overnight supervision).

4. This service does not include payment for non-medical transportation costs.

5. Payment for Community Support Services does not include room and board, or the cost of facility maintenance and upkeep.

6. Rate for this service and any additional waiver services cannot exceed the current highest daily rate for skilled nursing facility care.

7. Access of services or goods outside of the local area if the same service and goods are available in their local community.

    a. For example, a grocery store is available in the local community, but the consumer wants to drive to a larger community because they prefer that location, even though the product and cost is the same at both locations.

8. Travel and direct support outside of the individual's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.

9. Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.

10. A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized (acute hospital stay) or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty calendar days per year per participant.

    a. Absences do not include absences due to the individual receiving care in a skilled nursing facility (SNF) or Swingbed facility.

11. When there is a need for two QSP staff to provide assistance and the QSP agency is authorized the maximum 24 hour care rate, personal care services may be requested for consideration and approval. A request must be submitted to the program administrator including:

    a. an assessment by an Occupational Therapist (OT) or a Physical Therapist (PT) documenting the required need.
    b. the frequency of the task requiring the second staff person,
    c. and the total units needed for the task.
    d. The program administrator will review the request and determine if personal cares may be authorized for the second staff person.
    e. If there is an emergent need for 2 staff, the HCBS case manager will contact the program administrator for review and approval.

Program Administration enters the Preauth upon request from the provider verifying the dates the individual is temporarily absent from the integrated setting.

The provider must review the retainer payments in the IPP that is completed every 6 months.

This process is handled administratively through the approval of Residential Habilitation and Community Supports.

Providers

Community Support Services may **NOT** be provided by the following employees of a QSP agency:

- Legal spouse

Standards for Providers

Service must be provided by an enrolled Medicaid Agency. Individual QSP are not eligible to provide this service.

Community Support Service providers must be:

Agency QSPs enrolled under NDAC 75-03-23 may include Licensed community support services DD Providers- Licensed according to NDAC 75-04-01 who meet additional enrolment requirements and meet the following:

1. Provider must ensure that staff are adequately trained and qualified as evidenced by:

    a. Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills,

    b. Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01,

    c. Department approved training on Traumatic Brain Injury (TBI) and dementia,

        i. In-service training to direct contact staff by the program coordinator on implementation of

individual's programs and observation of implementation in the service setting.

ii. To assure staff meet minimum training requirements, TBI and dementia training must be completed within 30 days of providing care to an individual under community supports.

iii. Staff must complete TBI and dementia training every 2 years.

d. Completion of Minot State University medication modules, testing and practicum. Written test is proctored and completed in person. Practicum is administered by a licensed registered nurse employed or contracted through the Agency Provider.

i. Staff must complete department-approved training on the administration of routine medications before administering routine medications. This includes cueing/reminding the individual to take medication.

ii. Staff must demonstrate continued competency in medication administration by completing medication practicum with agency RN once yearly and as needed. Staff must complete the practicum checklist specific to the type of medication administration they will be completing (example: if administering an enema, staff must complete the practicum checklist for the administration of an enema prior to administration and yearly).

e. Agency must name a Program coordinator. Program coordinator requirements:

i. Must have at least one year of experience working directly with persons with physical disability; and

ii. Is one of the following:

a. A doctor of medicine osteopathy,

b. a registered nurse, or

c. an individual who holds at least a bachelor's degree and who is licensed, certified, or registered as applicable, to provide professional services by the State in which he or she practices (e.g. social worker, occupational therapist, psychologist, physical therapist, etc.).

   An individual with a "bachelor's degree in a human service field" means an individual who has received: at least a bachelor's degree form a college or university (master and doctorate degree are also acceptable) and has received academic credit for a major or minor coursework concentration in a human service field (including, but not limited to: sociology, special education, rehabilitation counseling and psychology)

d. Other:

   1. An individual who has a bachelor's degree; and
   2. completes the department approved TBI and Dementia training; and
   3. has one year of experience working with individuals with a physical disability.

iii. Ensures quality programs/services for the people supported in the employing agency.
iv. Responsible for development of the IPP.

Community Support Service agency providers may employ legally responsible individuals to provide Community Support Service. The following criteria applies when an agency employs a legally responsible person or family member as a staff to provide Community Support Service.

- Community Support Service cannot be provided by spouses,
- Community Support providers or staff cannot live with the care recipient.
- The legal guardian or family member must meet all the required qualifications of a Community Support Service staff member.
- If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the

recipient, the case manager must pre-approve the arrangement with the HCBS Program Administrator for Community Support Service.

- The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.

The narrative must also be attached to the client's individual care plan when it is submitted to the State.

2. Council on Quality & Leadership (CQL) Accreditation

    a. Provider must become CQL accredited. Refer to Council on Quality and Leadership (CQL) Accreditation Policy, see 525-05-47.

Residential Habilitation agency providers may employ legally responsible individuals to provide Residential Habilitation Service. The following criteria applies when an agency employs a legally responsible person or family member as a staff to provide Residential Habilitation.

- Residential Habilitation Service cannot be provided by spouses,
- Residential Habilitation providers or staff cannot live with the care recipient.
- Payment may be made to a legal guardian or family member by the provider agency if the recipient chooses the legal guardian or family member as their provider.
- The legal guardian or family member must meet all the required qualifications of a Residential Habilitation Service staff member.
- If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement with the HCBS Program Administrator for Residential Habilitation.
- The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.
- The narrative must also be attached to the client's individual care plan when it is submitted to the State.

<u>Involuntary Discharge of an Individual under Community Support Services:</u>

Involuntary discharge occurs when a Community Support Services provider has decided to discontinue services and terminate supports even though the individual has not requested the termination of services. Any opportunities to prevent an involuntary discharge should be explored prior to the discharge by the provider. Community Support Services providers must have written policies and procedures that define the conditions of termination and transfer of an individual's services. Individuals and/or legal decision makers should receive a copy of the provider's policy at the time of admission to the provider agency and again when a discharge is being considered.

In the case of an involuntary discharge, the Community Support Services provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting with the individual and HCBS case manager, and complete a written discharge summary. The timing of the thirty (30) day notice begins the date that the team meeting occurs. The written discharge notice must include the reason for discharge and why the provider cannot continue to serve the individual. A copy of the thirty (30) day notice and the written discharge notice must be forwarded to the HCBS Case Manager. The Community Support Services provider must also file a Critical Incident Report. Any opportunities to prevent discharge should be explored prior to discharge by the provider.

Settings where service can be provided

This service may be provided in a private family dwelling or in a licensed adult foster care home N.D.A.C. 75-03-21.1 that is approved to provide this service. The HCBS settings rule applies to all agency foster homes and the setting must be fully compliant before services can begin.

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**

Maximum Room and Board Rate effective 7-1-2024

The current maximum monthly room and board rate that providers may charge community support services recipients is $1005.00. The maximum room and board rate is equal to the current Medicaid medically needy

income level for a one person household less a $125 personal needs allowance. The rate is reviewed annually.

Providers are not required to charge a room and board rate and may choose to charge less than the maximum rate.

Family Personal Care 525-05-30-32

(Revised ~~12/01/2024~~ 6/1/2025 ML #~~3885~~3921)

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.

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 agreement with the care plan by signing the Person-Centered Plan of Care.

    a. In addition to the FPC providers signature on the care plan the Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all Family Personal Care Providers.

5. The individual must have a daily personal care and/or supervision need that is provided by the family personal care provider.

    a. When determining whether the individual has a daily personal care or supervision need, **do not include** homemaker tasks such as assistance with meal prep, laundry, shopping, housework, money management, or communication as part of the daily need.

6. The provider for FPC must provide a minimum total of three (3) hours of care to the eligible individual per day. The three (3) hours per day includes the daily personal care or supervision need and any other allowable task under FPC.

    a. The three hour of care per day may include homemaker tasks within the limits allowable under Medicaid Waiver.
    b. If family member is providing less than 3 hours of care per day, (including homemaker tasks allowable under the service cap) live-in care is to be provided under MSP-PC, T1020 with a provider agreement as long as the provider is eligible for MSP-PC.
        1. Three (3) hours per day may be calculated by taking the total number of units required per month x 12, divided by 365.

7. The number of reimbursable hours of care for this service cannot exceed 10 hours per day.

8. The need for services must fall within the scope of tasks identified on the Authorization to Provide Services, otherwise known as the Preauth.

9. Individuals with Live in Providers (except for Spouses or legal Guardians) may choose to have their services Under Medicaid State Plan Personal Care – Daily Rate (T1020). MSP-PC Note that T1020 does not include reimbursement for the task of supervision, but does reimburse for personal cares.

Service Tasks/Activities

The service tasks/activities within the scope of this service chapter are all inclusive, including personal care, cog/supervision, and homemaker.

1. Family personal care tasks include bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, supervision, exercises, hoyer lift/mechanized bath chairs, indwelling or external catheter, medical gases, prosthesis/orthotics, suppository/bowel program, ~~TED~~ compression sleeves or socks (e.g. TED Socks), temp/bp/pulse/respiration rate, apnea monitor, medically ordered compression device ~~jobst stockings~~, ostomy care, postural/bronchial drainage, and ~~RIK bed~~ pressure relief mattress care. The identified tasks for the individual are listed on the service authorization.
    a. The FPC provider must have global endorsements in order to be authorized for supervision, exercises, hoyer lift/mechanized bath chairs, indwelling or external catheter, medical gases, prosthesis/orthotics, suppository/bowel program, ~~TED~~ compression sleeves or socks, and temp/bp/pulse/respiration rate.
    b. The FPC provider must have client specific endorsements in order to be authorized for apnea monitor, medically ordered compression device ~~jobst stockings~~, ostomy care, postural/bronchial drainage, and ~~RIK bed~~ pressure relief mattress care.
    c. The FPC provider may be authorized for medication administration even if the individual is not able to self-direct their medications.

2. Homemaker tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service activity benefits the individual.
    a. The service of family personal care is not intended to be used primarily for environmental tasks. The individual must have a daily personal care and/or supervision need to qualify for this service.
    b. 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.

1. For care out of state, prior approval must be granted by the HCBS Program Administrator for each instance of out of state care.
2. No payment is allowed for care provided outside of the United States.

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.

- The provision does not allow for the Family Personal Care provider to work full time outside of the home unless the arrangement has been approved by an HCBS Program Administrator and assures the individual's continued health and safety.

Limitations

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

1. The number of reimbursable hours of care cannot exceed 10 hours per day.
    - The provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because of their close personal relationship and that they share a household with the eligible individual.
2. Under FPC, the tasks of housework, laundry, meal prep, shopping, money management, and community are considered homemaker tasks and are limited to the maximum monthly amount set by the Department.

Providers

Family Personal Care may be provided by the following individuals (**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. (Required)**

Note: A provider who is on Medicaid is not allowed to request a lower rate than what is calculated based on the service recipient's needs. Per Medicaid guidelines: if a provider is on Medicaid, all income available to that provider must be considered and counted.

- If a provider on Medicaid has questions about how payment will affect their eligibility, they should refer to their eligibility worker.
- If a provider receiving other financial assistance such as TANF, SNAP, housing assistance, SSI, etc. has questions about how payment with affect their eligibility, they should refer to the authorizing entity.

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~~ authorization, 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.

3. For some situations, it may be appropriate for two Family Personal Care providers to be authorized to provide care to one individual if both providers meet the Family Personal Care definition. However, both Family Personal providers cannot bill for the service on the same day. Pre-approval by program administration is required for services authorized in this manner. See Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50 for instructions on how the QSP Service Agreements are completed for these instances.

4. See Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50 for instructions on how the QSP Service Agreements are completed if

one Family Personal Care provider has been pre-approved to provide daily live-in care to more than one individual.

5. Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing to obtain approval.

Authorization

When an individual's live-in provider changes from a unit rate service to daily rate service, the case manager ends the unit-rate service the last day of the month and authorizes the daily rate service the first day of the next month.

- Example: an individual's provider is authorized for T1019 but becomes approved for Family Personal Care. The case manager ends T1019 the last day of the month and starts Family Personal Care the first day of the next month.

When an individual's live-in provider changes from one daily rate service to another daily rate service, the case manager ends the first service the last day of the month and authorizes the new service the first day of the next month.

- Example: An individual's provider is authorized for Family Home Care but becomes approved for Family Personal Care. The case manager ends Family Home Care the last day of the month and starts Family Personal Care the first day of the next month.

Residential Habilitation 525-05-30-50

(Revised 0~~2~~6/01/2025 ML# ~~3899~~3921)

Definition

Residential Habilitation is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

The participant must be able to benefit from skills training in order to assist individuals to independently complete tasks, restoration or maintenance and could also benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation.

This service may be most beneficial to individuals with cognitive impairments, brain injury, stroke etc.

Purpose

Residential Habilitation provides all-inclusive service, provided up to 24 hours per day, to individuals who otherwise would be in an institutional setting.

Service Eligibility

The individual receiving Residential Habilitation will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Services.

2. Requires some level of on-going daily support.

3. Requires skills training, restoration or maintenance.

4. The individual is capable of directing his/her own care or has a legally responsible party to act on the recipient's behalf.

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

Service Tasks/Activities

Care coordination is the primary responsibility of the Quality Service Provider (QSP) Agency Program coordinator. Authorized task includes:

1. Individual program Plan (IPP) Development, Coordination, Implementation and Evaluation.

a. Complete tasks such as individual plan development, monitoring the plan and observing to assure that the agency staff are trained, and the program is implemented, assisting with the development of behavior support techniques, assuring appropriate permission and approval is received from the individual and/or the legal decision maker.

b. Professional services are included in the "care coordination" hours and are not to be included in determination of direct support service hours.

Care coordination functions provided by the QSP agency include:

1. Management of an individual's property and resources including household budgeting, money management, communicating with creditors and landlords, etc.,

2. Application for generic services, monitoring status of those services, and maintaining communication with families, guardians, and other involved persons and agencies,

3. Coordinating medical needs,

4. Designing and implementing programs to enhance self-direction, independent living skills, community integration, social, recreational, and leisure skills and opportunities, and behavior management,

5. Facilitating the IPP planning process,

6. Assessing effectiveness of personal independence development strategies and other support services through analysis of information, consultation with the individual and/or guardian and family members, and observation of the person's programs and service settings,

7. Asserting and safeguarding the individual's human and civil rights, and

8. Attending to psychosocial needs of the individual.

Hours for direct staff time for personal supports include:

1. General supervision for safety and health monitoring and maintenance,
   a. If the individual is authorized for 24 hour 1:1 support, the QSP agency must ensure staff are present at all times. If the individual is able to be left alone for brief periods of time, this

information must be reviewed with the HCBS case manager and specified in the person-centered service plan and the IPP.

2. Homemaking which may include home maintenance,
3. Assistance with activities of daily living and instrumental activities of daily living
    a. bathing
    b. communication
    c. dressing/undress
    d. eyecare
    e. feeding/eating
    f. haircare/shaving
    g. housework
    h. incontinence
    i. laundry
    j. meal preparation
    k. mobility (inside/outside)
    l. Money Management
    m. nailcare (fingernails)
    n. shopping
    o. skincare
    p. teeth/mouth care
    q. toileting
    r. transferring/turning/positioning
4. Global Endorsements tasks

a. exercises
b. hoyer lift/mechanized bath chairs
c. indwelling catheter
d. medical gases
e. prothesis, orthotics
f. suppository, bowel program
g. TED socks
h. vitals

5. Client specific endorsements

a. apnea monitor
b. JOBST stockings
c. ostomy care
d. postural/bronchial drainage
e. RIK bed care

6. Medication administration

a. Under this chapter employees of an enrolled residential habilitation QSP agency who have received Department approved training may administer routine medications to recipients even if they are unable to self-direct their care. The QSP agency must employ or contract with a licensed registered nurse who provides supervision to the employees who are administering routine medications. The licensed nurse determines competency in medication administration by the employee's successful completion of the Department approved medication practicum. This does not include medications administered through a parenteral route (e.g. intravenous or intramuscular injections). The licensed nurse is responsible for ensuring that medications have been administered correctly according to the six rights of medication administration (individual, dose, time, route, medication, documentation), and that documentation is completed accurately.

b. The QSP agency must have a training protocol and policy established for the administration of all medications, including PRN medications. The registered nurse is responsible for the training and oversite of all medication administration.

c. The licensed registered nurse employed by the QSP agency may perform medication set-up.

7. Transportation to support medical, social, and essential community services.

8. Accompanying individual to medical appointments.

Hours for direct staff time for personal independence development:

1. Development of natural supports,

2. Activities and strategies to promote community inclusion/integration, leisure skill development, including activities to facilitate socialization and recreation that are tied to a therapeutic goal,

3. Support and adaptive strategies to enhance the person's control and independence over environment, resources, activities, and self- care, and

4. Training of skills development and/or maintenance.

Authorization for Services

1. The service tasks/activities within the scope of this service chapter must be identified in the assessment and on the Authorization to Provide Service.

2. An IPP as outlined in the Residential Habilitations provider standards, must be developed by the authorized QSP agency and maintained in the individual's file. An IPP is an individualized plan that describes the goals, wants, needs, and strengths of the person. It describes in detail how the QSP agency is supporting the individual.

    a. Service task and activities must be tied to an individual's goals as determined through the person-centered planning process.

    b. The IPP must correlate with the person-centered plan and service authorization that is completed by the HCBS Case Manager.

    c. The IPP must be developed by the QSP Agency Program Coordinator within the first 30 days of service provision and forwarded to the case manager and every 6 months thereafter.

    d. The IPP must also be reviewed and approved by the state program administrator.

e. The IPP must include:

i. A plan for promotion of the individual's independence in ADLs and IADLs, social, behavioral, and adaptive skills,

ii. Tasks being provided which should match the authorization provided by the HCBS case manager,

iii. A medication list if medication administration is authorized and description of how medications are being managed;

iv. Medical diagnoses;

v. A therapeutic goal for community integration activities which would include companionship and socialization activities. The individual should be involved in goal setting and ideas for these activities;

vi. Temporary absences and requests for retainer payments. Including any requests for retainer payments and dates of absences submitted to HCBS Program Administration for retainer payment authorization.

Note: Retainer payments cannot exceed 30 days per calendar year.

vii. Signature of the agency care coordinator and date.

Reasonable Modification:

To comply with Title II of the ADA, a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. Refer to: Requests for Reasonable Modification 525-05-55.

This service may include nursing care to the extent permitted by state law under NDCC 43-12.1 and NDAC 54-05, which will maintain the health and well-being of the individual and allow the individual to remain in the community. Approval of tasks medical in nature under Residential Habilitiation services are services that an individual without a functional disability would customarily and personally perform without the assistance of a licensed health care provider, such as administration of medications, or wound care.

If a modification is approved under the Residential Habilitiation Program to complete tasks that are medical in nature and that are specific to the needs of an eligible individual, a Registered Nurse (RN) must complete an assessment to determine if the tasks will be completed by the RN or trained to the QSP agency

staff. If a necessary medical task is too complex to be taught to the QSP agency staff, the nurse may provide the service directly to the individual.

The QSP agency must submit:

1. Agency policy specific to the medical task being completed
2. Evidence of training of the QSP agency staff by the RN using the **SFN 585**.
3. Example of how they will document these tasks
    a. Nursing task documentation should align with the professional nursing documentation requirements/standards to ensure accuracy and consistency.
4. A copy of the IPP to include an explanation of tasks that will be delegated, tasks performed by the nurse, and how the nurse will provide an oversight of these tasks. The **SFN 585** along with the IPP is required initially within the first **48 hours** of services beginning, every 6 months, and annually. If there are medical tasks being performed, the RN must sign and date the IPP along with the Care Coordinator.

Allowable Service Combinations

Chore, ERS, Environmental Modification, Adult Day Care, Supported Employment, Extended Personal Care includes Nurse Education, Home Delivered Meals, Transition Coordination, Specialized Equipment,

Limits

Residential Habilitation may not be authorized with Respite Care, Homemaker, Adult Foster Care, Family Home Care, Personal Care, Family Personal Care, Adult Residential, Transitional Living, Attendant Care, Supervision, Companionship, Community Support Services and Non-Medical Transportation. For unusual or unique circumstances, contact the Aging Services Program Administrator for approval consideration.

1. This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.

2. Supervision may not be authorized in excess of what is necessary for health and safety.

    a. For example, the family is requesting that someone stay with their relative 24 hours per day when there is not a safety or health risk other than the possibility that something might happen.

b. Supervision may not be used to restrict an individual from alcohol or substance use.

3. Twenty-four hour supervision in a shared living environment- Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the individual or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.

    a. A safety threat means the individual is so aggressive, self-destructive, or requires such close supervision that any attempt to share one-on-one staff at any time will place the individual at immediate risk.

    b. Shared tasks will be considered in the shared living environment, and may affect the daily rate for these services (e.g. housekeeping of common areas, shared meals preparation, and overnight supervision).

4. This service does not include payment for non-medical transportation costs.

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

6. Rate for this service and any additional waiver services cannot exceed the current highest daily rate for skilled nursing facility care.

7. Access of services or goods outside of the local area if the same service and goods are available in their local community.

    a. For example, a grocery store is available in the local community, but the consumer wants to drive to a larger community because they prefer that location, even though the product and cost is the same at both locations.

8. Travel and direct support outside of the individual's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.

9. Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.

10. A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized (acute hospital stay) or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty calendar days per year per participant.

    a. Absences do not include absences due to the individual receiving care in a skilled nursing facility (SNF) or Swingbed facility.

11. When there is a need for two QSP staff to provide assistance, personal care services may be requested for consideration and approval. A request must be submitted to the program administrator including:

    a. An assessment by an Occupational Therapist (OT) or a Physical Therapist (PT) documenting the required need,
    b. The frequency of the tasks requiring the second staff person,
    c. And the total units needed for the task.
    d. The program administrator will review the request and determine if personal cares may be authorized for the second staff person.

Program Administration enters the preauth upon request from the provider verifying the dates the individual is temporarily absent from the integrated setting.

The provider must review the retainer payments in the IPP that is completed every 6 months.

This process is handled administratively through the approval of Residential Habilitation and Community Supports.

Providers

Residential Habilitation may **NOT** be provided by the following employees of a QSP agency:

- Legal spouse or parent of a minor child.

Standards for Providers

Service must be provided by an enrolled Medicaid Agency. Individual QSPs are not eligible to provide this service.

Residential Habilitation providers must be:

Agency QSPs enrolled under NDAC 75-03-23 may include Licensed residential habilitation DD Providers- Licensed according to NDAC 75-04-01 who meet additional enrolment requirements and meet the following:

1. Provider must ensure that staff are adequately trained and qualified as evidenced by:

    a. Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills,

    b. Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01,

    c. Department approved training on Traumatic Brain Injury (TBI) and dementia,

        i. In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.

        ii. To assure staff meet minimum training requirements, TBI and dementia training must be completed within 30 days of providing care to an individual under residential habilitation.

        iii. Staff must complete TBI and dementia training every 2 years.

    d. Completion of Minot State University medication modules, testing and practicum. Written test is proctored and completed in person. Practicum is administered by a licensed registered nurse employed or contracted through the Agency Provider.

        i. Staff must complete department-approved training on the administration of routine medications before administering routine medications. This includes cueing/reminding the individual to take medication.

        ii. Staff must demonstrate continued competency in medication administration by completing

medication practicum with agency RN once yearly and as needed. Staff must complete the practicum checklist specific to the type of medication administration they will be completing (example: if administering an enema, staff must complete the practicum checklist for the administration of an enema prior to administration and yearly).

e. Agency must name a Program coordinator. Program coordinator requirements:

1. Must have at least one year of experience working directly with persons with physical disability; and

2. Is one of the following:

a. A doctor of medicine osteopathy,

b. a registered nurse, or

c. an individual who holds at least a bachelor's degree and who is licensed, certified, or registered as applicable, to provide professional services by the State in which he or she practices (e.g. social worker, occupational therapist, psychologist, physical therapist, etc.). An individual with a "bachelor's degree in a human service field" means an individual who has received: at least a bachelor's degree from a college or university (master and doctorate degree are also acceptable) and has received academic credit for a major or minor coursework concentration in a human service field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

d. Other:

i. Individuals who have a bachelor's degree; and

ii. Completes the department approved TBI and Dementia training; and

iii. Has one year experience working with individuals with a physical disability.

3. Ensures quality programs/services for the people supported in the employing agency.

4. Responsible for development of the IPP.

2. Council on Quality & Leadership (CQL) Accreditation

a. Provider must become CQL accredited. Refer to Council on Quality and Leadership (CQL) Accreditation Policy, see 525-05-47.

Residential Habilitation agency providers may employ legally responsible individuals to provide Residential Habilitation Service. The following criteria applies when an agency employs a legally responsible person or family member as a staff to provide Residential Habilitation.

- Residential Habilitation Service cannot be provided by spouses,
- Residential Habilitation providers or staff cannot live with the care recipient.
- Payment may be made to a legal guardian or family member by the provider agency if the recipient chooses the legal guardian or family member as their provider.
- The legal guardian or family member must meet all the required qualifications of a Residential Habilitation Service staff member.
- If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement with the HCBS Program Administrator for Residential Habilitation.
- The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.
- The narrative must also be attached to the client's individual care plan when it is submitted to the State.

<u>Involuntary Discharge of an Individual under Residential Habilitation:</u>

Involuntary discharge occurs when a Residential Habilitation provider has decided to discontinue services and terminate supports even though the

individual has not requested the termination of services. Any opportunities to prevent an involuntary discharge should be explored prior to the discharge by the provider. Residential Habilitation providers must have written policies and procedures that define the conditions of termination and transfer of an individual's services. Individuals and/or legal decision makers should receive a copy of the provider's policy at the time of admission to the provider agency and again when a discharge is being considered.

In the case of an involuntary discharge, the Residential Habilitation provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting with the individual and HCBS case manager, and complete a written discharge summary. The timing of the thirty (30) day notice begins the date that the team meeting occurs. The written discharge notice must include the reason for discharge and why the provider cannot continue to serve the individual. A copy of the thirty (30) day notice and the written discharge notice must be forwarded to the HCBS Case Manager. The Residential Habilitation provider must also file a Critical Incident Report. Any opportunities to prevent discharge should be explored prior to discharge by the provider.

Settings where service can be provided:

This service may be provided in a private family dwelling or in a licensed adult foster care home N.D.A.C. 75-03-21.1 that is approved to provide this service. The HCBS settings rule applies to all agency foster homes and the setting must be fully compliant before services can begin.

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**

Maximum Room and Board Rate effective 7-1-2024

The current maximum monthly room and board rate that providers may charge residential habilitation recipients is $1005.00. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a $125 personal needs allowance. The rate is reviewed annually.

Providers are not required to charge a room and board rate and may choose to charge less than the maximum rate.

Supervision 525-05-30-63

(Revised 0~~3~~6/01/202~~4~~5 ML #~~3829~~3921)

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.

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 SPED personal care, Medicaid State Plan personal care, waiver 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, hoyer 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. 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.
    - 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 care, 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 supervision or other services are 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. Supervision does not include taking/transporting recipients out of the home to community/social events etc.
    - 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 authorized with the following services, but payment for supervision cannot be claimed, during the time these services are being provided: Homemaker, Respite Care, Extended Personal Care, Chore, Non-Medical Transportation, Medicaid State Plan Personal Care, Transitional Living, Supported Employment, Adult Day Care, Community Transition Services and Companionship Services. Supervision cannot duplicate the services provided under

Transitional Living. ~~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, unit-based personal care, respite care, transitional living, specialized equipment, and supported employment.~~

3. To avoid duplication of services, Supervision cannot be combined with: Adult Foster Care, Residential Services, Residential Habilitation, Community Support and Family Personal Care as supervision is already an allowable task under these services. ~~Supervision cannot be combined with emergency response system, adult foster care, residential services, and family personal care.~~

4. Supervision cannot be combined with an Emergency Response System as this service is not meant to replace the need for human intervention. For unusual or unique circumstances, approval from the HCBS Program Administrator must be obtained.

5. In circumstances where live-in providers are seeking to provide personal care under a unit rate, combined with supervision, the case managers must seek prior-approval for this service combination.

6. For unusual or unique circumstances, contact the HCBS Program Administrator in writing for consideration as a potential reasonable modification based on the totality of the circumstances.

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.**

When an individual is requesting supervision by a live-in relative meeting the definition of a "family member" or a live-in provider who has a close personal relationship with the individual to be authorized, consult with program administration for consideration. This includes individuals who may be hired to provide care under a QSP agency.

Waiver Personal Care 525-05-30-75

Revised ~~12/01/2024~~ 6/1/2025 ML #~~3885~~3921)

Purpose

The purpose of Waiver Personal Care (WPC) is to provide a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a physical disability.

Service Description

Waiver Personal Care assistance may take the form of hands-on assistance (actually performing a task for the person), cuing to prompt the participant to perform a task or being at the ready to assist with the tasks due to the individuals intermittent need for personal care and supervision. Such

assistance may include assistance in performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, i.e., light housework, laundry, meal preparation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of participants as provided in the service plan.

Service Eligibility, Criteria for

The individual receiving Waiver Personal Care service will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community-Based Services.
2. Requires on-going daily support with the combination of personal care and supervision as defined under waiver services of Waiver Personal Care and Supervision.
3. The individual must be capable of directing their own care or has a legally responsible party to act on the recipient's behalf.

Service Tasks/Activities

The care needs of the individual must fall within the scope of personal care service as described in this service chapter. The care needs may include a combination of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Either the individual must have the ADLs and IADLs needs performed for him/her OR an individual with cognitive impairment may be able to complete the activity ONLY with supervision, guidance, or prompting.

1. Personal Care tasks that may be included in Waiver Personal Care are as follows: bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, cog/supervision, exercises, hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.
2. The task of supervision is allowed between other personal care tasks, if the individual requires supervision/oversight due to physical or cognitive impairment, or to be at the ready to provide personal care

services when personal cares are required intermittently throughout the day.

Supervision means having the knowledge of, and account for, the activity and whereabouts of the recipient at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. Supervision includes the provider being immediately available to furnish assistance and direction throughout the performance of and/or at the ready to perform the next personal care task (i.e. bathing, toileting, transferring, locomotion etc.) that is necessary to meet the intermittent personal care need of the participant.

3. Homemaker (laundry, shopping, and housekeeping) tasks are to be included in the service of WPC.
    - The service of waiver personal care is not intended to be used primarily for environmental tasks. The individual must have a daily personal care and/or supervision need to qualify for this service.

Waiver Personal Care (WPC) may be provided on an episodic or on a continuing basis.

WPC is an all-inclusive service that combines personal care services, intermittent personal care, supervision, homemaker and limited to the amount of time that care is provided to the eligible individual while moving from task to task or completing tasks simultaneously within the authorized amount of time.

Example 1: If the provider is providing supervision, PCS at the ready, hands-on PCS, meal preparation and homemaker.

- Such as, a provider may be providing supervision and preparing a meal at the same time then move to assisting with PCS and then completing homemaker tasks. The all-inclusive nature of WPC allows for all the tasks to be completed while the provider is clocked in under the one service of waiver personal care.

Example 2: If the individual requires assistance with personal care, supervision, meal prep, and homemaker all in one day/shift, the provider can provide all of these tasks while remaining clocked in under the service of Waiver Personal Care.

- Such as, an individual requires staff to be in the home and at the ready for PCS tasks and there are homemaker tasks or a meal that needs to be prepared. It is allowable for the QSP to provide the services simultaneously, and does not require units for each task to

be authorized independently, however the task itself must be authorized under the service plan and authorization.

Waiver Personal Care Daily Live-in Providers

Live-in waiver personal care (daily) is all inclusive of personal care, supervision and homemaker services.

Waiver Personal Care Daily live-in must be authorized if the non-family provider and the individual live in the same residence and personal care and supervision is needed on a daily basis.

1. If personal care/supervision is not needed on a daily basis, Waiver Personal Care Daily live-in should not be authorized.
2. If there are multiple waiver personal care providers necessary to meet the individual's need, it is allowable for unit-based waiver personal care to be authorized instead of waiver personal care daily.

Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all live in WPC Daily Personal Care Providers.

~~Exception: When a live-in relative meeting the definition of a "family member" or a live-in provider who has a close personal relationship with the individual would like to be hired under an agency to provide Waiver Personal Care Unit Rate, consult with program administration for consideration.~~

Limits/Service Combinations

1. To avoid duplication, waiver personal care recipients are not eligible for adult residential care, adult foster care, residential habilitation, and community support services.
2. Waiver Personal care differs from adult foster care in that personal care is provided in the individual's home, and adult foster care is provided in the service provider's home. If a non-relative is caring for the individual on a 24-hr live in basis in the provider's home, the service must be Adult Foster Care. It cannot be Waiver Personal Care service.
3. Waiver personal care differs from respite care in that respite care is provided to relieve the primary, live-in caregiver, whereas the primary purpose of waiver personal care is to provide the care an individual needs and not to relieve the caregiver.
4. Homemaker (Laundry, shopping, and housekeeping) tasks when provided as a waiver personal care service limited set by the department, and the cap cannot be exceeded under other waiver services.

5. The number of reimbursable hours of care for an Individual Qualified Service Provider (QSP) of this service cannot exceed 12 hours per day.
6. The state assures WPC being provided to the participant are not duplicative of extended personal care as WPC does not include hands-on care of a medical nature that is specific to the needs of an eligible individual that is provided under extended personal care. The state ensures non-duplication with extended personal care through thorough assessment and monitoring of participant services through person centered planning.
7. Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the state plan. Waiver Personal Care differs in scope and nature from the personal care offered under the State Plan as supervision may be provided under WPC. A participant cannot be authorized to receive both services at the same time.
8. When WPC is provided by a non-agency provider, participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the case manager performs monitoring of a participant's person-centered plan with the participant. This monitoring includes monitoring of the use or non-use of waiver services. At a minimum, this monitoring occurs on a quarterly basis.
9. The individual or legally responsible person must direct the care provided and should be involved in training and monitoring the WPC QSP as much as possible and when appropriate.
10. Personal care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). If an individual under age 21 is seeking waiver services, the case must be staffed with program administration.

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**

Waiver Personal Care is furnished both inside and outside the participant's home and community. WPC may be provided outside the participants home when the participant is needing personal cares while outside of their home.

Example: If the individual needs personal care assistance hands on or at the ready to provide services outside of the home to meet their needs. It is allowable under WPC. WPC cannot be used in lieu of Companionship (to include community integration and socialization), Extended Personal Care or Non-medical Transportation-Escort.

Personal care may be furnished in order to assist a person to function in the workplace or as an adjunct to the provision of employment services.

Providers

Waiver Personal Care Daily Rate may be provided by **(checked if allowable):**

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

Waiver Personal Care Unit Rate may be provided by **(checked if allowable):**

- ✓ **Legally Responsible Person**
- ✓ **Relative (Live-in relatives meeting the definition of family member under subsection 4 of N.D.C.C. 50-06.2-02 are not eligible to provide this service. See "Standards for Waiver Personal Care Providers" for explanation and exceptions)**
- ✓ **Legal Guardian**

Standards for Waiver Personal Care Providers

All providers of waiver services must be enrolled Qualified Service Provider N.D.A.C. 75-03.23-07.

Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all live in Waiver Personal Care Daily Providers.

When WPC is provided by a non-agency provider, participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the case manager performs monitoring of a participant's person-centered plan with the participant. This monitoring includes monitoring of the use or non-use of waiver services. At a minimum, this monitoring occurs on a quarterly basis.

WPC Daily Rate Providers must:

1. Be live in caregivers of Medicaid Waiver eligible individuals who provide daily personal care (including being at the ready to provide intermittent personal cares and/or supervision.)
2. Have a close personal relationship with eligible individuals.
3. If more than one live in QSP is an authorized provider, do not use a daily rate. The services should remain as WPC unit rate.
4. Complete a Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654.

Live-in Paid Caregivers

Live-in relatives meeting the definition of family member under subsection 4 of N.D.C.C. 50-06.2-02 are not eligible to provide Waiver Personal Care service. This service is provided under Family Personal Care. This includes live-in family members who are hired or seeking to be hired under an agency provider. They are not eligible to provide Waiver Personal Care.

Exceptions:

Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing for consideration as a potential reasonable modification based on the totality of the circumstances. ~~to obtain approval.~~

~~Examples of exceptions may include:~~

- ~~Consideration may be given if the live-in family member does not qualify for Family Personal Care because they are providing less than 3 hours of care per day.~~
- ~~If an outside provider is the primary caregiver and the live-in-family member provides supplemental cares only, the live in family member provider may be eligible to receive WPC unit rate services limited to the cap for live-in family providers with prior approval of Program Administration.~~
    - ~~If program administration approves the live-in family member for WPC unit rate service, the number of reimbursable hours of care cannot exceed 10 hours per day. The live-in family member provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because of their close personal relationship and that they share a household with the eligible individual.~~

~~Contact the HCBS Program Administration to request an exception or reasonable modification to meet the individual need if the individual is at risk of institutional placement.~~

See Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50 for instructions on how the QSP Service Agreements are completed if one Waiver Personal Care provider has been pre-approved to provide daily live-in care to more than one individual.

Authorization

When an individual's live-in provider changes from a unit rate service to daily rate service, the case manager ends the unit-rate service the last day of the month and authorizes the daily rate service the first day of the next month.

- Example: an individual's provider is authorized for T1019 and Supervision but becomes approved for Waiver Personal Care Daily The case manager ends T1019 and Supervision the last day of the month and starts Waiver Personal Care Daily the first day of the next month.

When an individual's live-in provider changes from one daily rate services to another daily rate service, the case manager ends the first service the last day of the month and authorizes the new service the first day of the next month.

- Example: An individual's provider is authorized for T1020 but becomes approved for Waiver Personal Care Daily. The case manager ends T1020 the last day of the month and starts Waiver Personal Care Daily the first day of the next month.

See Standards for Qualified Service Providers 525-05-45

Maximum Monthly Amount - Aggregate and Per Service 525-05-35

(Revised 0~~2~~6/01/2025 ML #~~3899~~3921)

The maximum amount allowable under the Medicaid Waiver for Home and Community Based Services per Medicaid waiver recipient and per month is an aggregate of the cost and is limited to the highest monthly rate allowed

to a nursing facility within the rate setting structure of the Department of Human Services.

See link below:

2024 Nursing Facility rates.xlsx (nd.gov)

The maximum amount allowable under the SPED and ExSPED Programs per individual and per month is an aggregate of $4029 for all services excluding Adult Foster Care. If an individual is receiving Adult Foster Care under SPED or ExSPED, the maximum amount allowable is $6,796.

Homemaker Service	70 units
Respite Care	$1247 (Daily amount not to exceed daily swing bed rate). Refer to link: ~~https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/swing-bed-fee-schedule.pdf~~ https://www.hhs.nd.gov/healthcare/medicaid/provider/long-term-care-services
Respite Care in Homes with Multiple Residents	$1247 split by the total number of public and private pay residents in the home. Plus $224.94 per month for each additional (2nd 3rd or 4th) public pay residents in the home, the total amount will need to be divided between the public pay residents. For Example: An AFC provider has a total of 3 residents, 2 are public pay & 1 is private pay. To calculate respite for the public pay residents you should divide the current respite cap ($1247) by the total number of public & private pay residents living in the home (3) that equals $415.67 for each resident or $831.34 for the 2 public pay residents combined. Now add $224.94 for the 2nd public pay resident that equals $1,056.28. Now divide that amount between the 2 public pay residents $1,056.28/2 = $528.14.

	The final step is to allocate $528.14 on each of the public pay resident's care plan.
Adult Foster Care	$154.50 flat rate per day
Family Home Care	$74.68 flat rate per day
Family Personal Care	$159.54 flat rate per day
Daily Rate for SPED Personal Care	$87.76 flat rate per day
SPED Personal Care Assisted Living	$87.76 per day

When authorizing services that will be paid at the rural differential rate service maximums may be exceeded but the number of units cannot exceed the number of units that are available when using the original service maximum. It is allowable for costs to exceed the service maximum if RD is the **only** factor causing it to exceed the cap and costs are within the service maximum when calculating the base rate. This also applies to the respite care cap.

- Example 1 (monthly respite care cap): An individual resides 70 miles from the agency respite care provider and RD applies. The individual is requiring the maximum amount of respite care per month, which is 157 units. It is allowable for respite care to exceed the monthly maximum of $1247 because the only factor that causes it to exceed is the additional cost of the RD rate. When calculating the base rate of respite, 157 units falls within the cap.

- Example 2 (daily respite care cap): An individual resides 70 miles from the agency respite care provider and RD applies. The individual requires overnight respite care & the daily respite care cap is limited to the swing bed daily cap. Under these guidelines, the agency would be allowed to bill a maximum of 46 units of respite care per day. Even though the RD rate will add on an additional cost to this service, it is allowable as that is the only factor causing it to exceed the swing bed cap.

Service Maximums Per Individual Per Month for Dates of Service.

Extraordinary Costs/Exceed Monthly Aggregate or Service Maximum

This policy provides for additional dollars that may be needed because of an individual's special or unique circumstances that warrant a temporary exception of department policy. IT IS TIME LIMITED.

The HCBS case manager must submit in WRITING a request to exceed the monthly service or funding source maximum prior to authorizing the service(s) in excess of the monthly maximum. The request is to be sent to the HCBS Program Administrator to include:

- Name, county of residence, and ID number of the individual.
- Reason for the request: the individual's circumstances that necessitate the short duration extraordinary costs AND what options were explored as alternatives to meeting individual's need.
- The additional dollar amount request, for what funding source, service(s), and for what period of time.

The program administrator will notify the case manager in writing of the department's decision. It will include the conditions under which the approval is granted AND the procedure for the Qualified Service Provider to bill for the additional funds.

Maximum Room and Board Rate effective 7/1/2024

The current maximum monthly room and board rate that providers may charge Adult Foster Care, Adult Residential and Family Home Care recipients is $1,005.00. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a $125 personal needs allowance. The rate is reviewed annually.

Providers are not required to charge a room and board rate and may choose to charge less than the maximum rate.

Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50

(Revised ~~12/01/2024~~ 6/1/2025 ML# ~~3885~~3921)

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. Live-in Paid Caregivers

   Live-in relatives meeting the definition of family member under subsection 4 of N.D.C.C. 50-06.2-02 are not eligible to provide Waiver Personal Care service. This service is provided under Family Personal Care.

   ~~Exceptions may include:~~

   ~~a. Consideration may be given if the live-in family member does not qualify for Family Personal Care because they are providing less than 3 hours of care per day.~~

   ~~b. If an outside provider is the primary caregiver and the live-in family member provides supplemental cares only, the live in family member provider may be eligible to receive WPC unit rate services limited to the cap for live-in family providers with **prior** approval of Program Administration.~~

      ~~1. If program administration approves the live-in family member for WPC unit rate service, the number of reimbursable hours of care cannot exceed 10 hours per day. The live-in family member provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because of their close personal relationship and that they share a household with the eligible individual.~~

~~5. 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)~~ daily rate is 12 hours ~~unless prior approval was granted by HHS~~.

Exceptions:

Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing for consideration as a potential reasonable modification based on the totality of the circumstances.

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 recoupled:

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.~~
        - ~~This service must be billed using attendance billing documentation.~~
    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 Family Home Care and Family Personal Care QSPs use the paper atypical forms or the MMIS portal for billing.

<u>Two Live-in Providers for One Individual</u>

If an individual is pre-approved to receive care from more than one Family Home Care or Family Personal Care provider: the "Number of Hours of Care Provided Per Day" listed on the QSP Service Agreement does not have to be split between the providers. The full hours of daily cares are listed for each provider, not to exceed the maximum. While both providers are providing daily care, they are not allowed to bill for the individual on the same date of service.

a. For Example: Due to the needs of an individual, it is approved for two Family Personal Care providers to both provide care to an individual. Both may provide daily cares, yet each bill different days out of the month.

Service documentation for the providers must reflect the actual time and tasks provided by each of the providers for the dates of service.

Live-in Providers Caring for more than on HCBS Recipients

If a live-in provider under Family Personal Care, Family Home Care, Medicaid Waiver Personal Care Daily, or SPED or MSP Personal Care Daily is approved to provide live-in daily care to more than one service recipient, the "Number of Hours of Care Provided Per Day" listed on the QSP Service Agreement must be split between the total number of live-in daily care service recipients.

a. The reason the time is split between the participants is because a provider is limited to the maximum of 10 hours per day of HCBS services. The time is split between the two authorized participants for a total of no more than 10 hours per day.
    - The ratio of the split in time should be split by the ratio of time that service is provided to each participant.

Example 1: One individual may require 7 hours of care and the other individual may require 3 hours per day, the time would be split to reflect this need.

Example 2: If a provider is authorized for two Family Home Care recipients and both are assessed at needing the maximum of 10 hours of care per day, each individual's service agreement would list 5 hours per day.

SPED Income and Assets, SFN 820 525-05-60-20

(Revised ~~03/01/2024~~ 6/1/2025 ML #~~3829~~3921)

Purpose: In order for individuals to access the SPED program, information regarding assets, income, and deductions must be obtained to determine SPED program financial eligibility.

The SFN 820 must be completed (at a minimum) at the time of application and annually thereafter. If there is a significant change to the individual's financial resources or documented deductions, a new SFN 820 must be completed and signed by the individual if the individual remains eligible for SPED program services.

If a question arises on how to count a particular asset or income that is not covered in this section the HCBS Program Administrator will consult with State Medicaid Eligibility staff for guidance. Medicaid financial eligibility

criteria may be used to make decisions involving SPED eligibility not covered in policy.

The information obtained on the SFN 820 must correlate with the web-based data collection system SPED financial section ~~Income and Asset worksheet~~.

CLIENT INFORMATION – record the individual's name, Client identification number, individual's address, ~~whether or not they are covered members of health insurance~~, and whether or not they are recipients of Medical Assistance. (If they are QMB or SLMB only – do not record "yes". Only record yes if they are receiving Medicaid ~~State Plan medical and/or personal care services~~.)

ASSETS

The total amount of funds held in any type of joint account is considered an available asset to the applicant/client unless the applicant/client can verify that the funds are, in fact, the sole possession of only one owner that has the generally recognized authority to direct disbursement. When the applicant/client claims that he/she is NOT in possession of the funds AND CANNOT direct their disbursement, substantiating documentation must be included in the case file. The applicant's/client's oral statement alone is not sufficient. This statement applies to all types of assets.

> **Just as the income of the spouse must be considered in completion of SFN 820 SPED Income and Asset form, all liquid assets of the spouse must be considered in determining SPED Program eligibility even if the applicant/spouse's name is not on the statements or accounts. See N.D.C.C. 14-07. This applies also to applicants who have pre-nuptial or ante-nuptial agreements. The statutory obligation to support and care for a spouse is not negated by such agreements nor whether the spouse's name is included on financial documents.** However, you do not need to count the income or assets of the spouse if the applicant or recipient states that there has been a marital separation, with or without court order, and the spouses are currently living in separate households and have not separated for the purpose of securing HCBS benefits.

A1 Crop inventory: Non-contract crops held in storage at the discretion of the owner, who is the applicant/client, is considered a liquid asset for purposes of the SPED Program. However, crops being held for feed or for planting would not be included as an available asset. The cash value is based on the market price on the date of application or annual review.

A2 Cash – includes: Coins, currency, checking, savings accounts, money market accounts, and/or Certificates of Deposit. Include all accounts the individual has access. Funds held or prepaid for funeral accounts are also considered assets and cannot be deducted for the purposes of determining SPED eligibility. Any income or dividends received are reported as income, not in the asset section.

A3 Bonds – savings bonds, treasury bonds, others. Record the face value of the bond. The earnings are reported in the income section of this form.

A3 Mutual Funds - A type of mutual fund that allows investors to write checks against their account in established increments. The earnings are reported in the income section.

A3 Stocks – the current value of the stock is reported in the asset section, the dividends are reported in the income section.

A3 Trusts - All trusts must be submitted to ~~Medical Services~~ HCBS Program Administrator to coordinate review with the Legal Advisory Unit to determine how the trust will affect financial eligibility. In order for a determination to be made, the Legal Advisory Unit will need to review a copy of the full trust document (provided by the applicant) as well as the SFN 1947 (completed by the HCBS Case Manager).

A4 Retirement programs: Earnings on retirement programs are tax deferred until taking payouts. At that time the income is

reflected on their federal income tax form. If the individual will realize a penalty for an early withdrawal from the retirement account, the retirement account would be exempt.

A5 Residence other than Primary residence – individuals owning more than one residence~~,~~ must report residence other than the primary residence as a liquid asset. If the individual owns more than one residence, the value of the other property, less the secured debt owed for the property, that is not the primary residence is counted in determining the financial eligibility. In order to obtain the value, you may use a recently completed appraisal, or verify documentation from the county assessor showing the assessed value. If this documentation cannot be obtained, the fair market value can be obtained by contacting real estate or lending institution personnel.

Individuals residing outside of their home: If an individual is residing outside of their residence, that residence must be considered as an asset if not otherwise occupied. A residence is considered occupied when occupied by self, spouse, or minor dependent OR when the individual is temporarily absent but possesses the ability to return within a certain length of time which is reasonable. A reasonable length of time is six months. If an individual owns a home in which they no longer reside but chooses to rent it out for fair market value, the rent is considered part of the individual's income and the home is not counted as an asset. However, if they choose not to rent it out, the home value must be counted as an asset.

A6 Other Liquid Assets - The face value of loans that the applicant/client has made to others (money owed to the applicant/client) is also a liquid asset. Common loans are notes, and mortgages. Contracts for Deed and Limited Partnerships are excluded due to the difficulty of establishing a current market value for such instruments on the open market. Liquid assets may also include the value of vehicles owned other than the individual's primary vehicle. For example, if an individual owns two vehicles, one would be excluded but the other's value would be included as an asset. If a married couple owns three vehicles the first two would be excluded but the third's value would be included as an asset. The asset amount is calculated by taking

the value of the vehicle, less the secured debt owed for the vehicle.

A7 Total Assets – if using the electronic (e-forms) SFN 820, the amounts entered for assets will automatically sum and be recorded on this line. If using the paper copy of the SFN 820, add the amounts from the asset types and record the sum on this line.

A8 Disqualifying transfers – If a current SPED client has transferred or assigned assets for the purpose of continuing to make themselves eligible for SPED services, or to reduce the amount of their service payment or if an applicant has transferred or assigned assets within five years of the date they initially applied for SPED to make themselves eligible for services check yes, this is considered a disqualifying transfer. If you checked yes, please describe the nature of the disqualifying transfer. Any possible disqualifying transfers must be staffed with Program Administration as a disqualifying transfer will result in ineligibility for SPED. The Legal Advisory Unit may be contacted to make a determination as to whether a disqualifying transfer has occurred.

A9 Money and assets in a North Dakota Achieving a Better Life Experience (ABLE) Plan are not considered for the purpose of determining eligibility in order to receive SPED services. Total annual contributions into an ABLE account may not exceed the federal gift tax limit of $15,000. ABLE accounts up to $100,000 do not affect asset limits for SPED financial eligibility.

Verifying Assets

The individual must provide their most recent federal income tax form 1040 AND the most recent monthly, quarterly or annual statement from the company(s) holding such liquid assets. If the individual does not make the documents available, eligibility cannot be established. Therefore, eligibility is denied or terminated. If the individual did not file a tax return

for the previous year, other documentation must be obtained. Such documentation may include, but may not be limited to:

1. Bank statements
2. Monthly/Quarterly/Annual financial statements from the investment/financial institution(s)
3. Employer reporting statements
4. Contracts or other legal documentation

By reviewing these documents, the HCBS case manager can confirm the value of the liquid assets as well as the income derived from accounts or arrangements.

Exempt (Liquid) Resources

Excluded when calculating the value of the applicant's/client's resources are:

1. Cash surrender of life insurance policy(s).
2. Annuities or other pension plans IF a penalty would be imposed for withdrawal at the time of application or redetermination of eligibility. (e.g. There would be a penalty for withdrawal of funds from an IRA if the applicant/client is under 59 years.)
3. Any amount necessary for the fulfillment of a Plan for Achieving Self-Support (PASS) under Title XVI of the Social Security Act (SSI) will NOT be counted as an asset.
4. Contracts for deed or limited partnerships. Contracts for deed and limited partnerships are excluded due to the difficulty of establishing a current market value for such instruments on the open market.
5. Limited Partnerships.

Funds held or prepaid for funeral accounts cannot be deducted for the purposes of determining SPED eligibility.

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Asset Detail – record the Asset Type, Institution/Organization, Invoice/Statement Date, and Statement Amt or Balance. Examples:

Individual has $342 in checking, $200 in savings, $23 in cash, and $12,475 in a retirement account.

Asset Type	Instit/Organ	Invoice/St. Date	St. Amt or Balance
Cash	Smith Credit Union	July 8, 2005	$342
Cash	On-hand		$23
Retirement Prog.	NP Railroad	July 1, 2005	$12,475

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Section 1, HOUSEHOLD INCOME SECTION

If the primary income comes from self-employment, or a combination of salaries and self-employment, add the monthly amounts from the income sources.

If a client has self employment income but does not have a tax return reflecting this income, disregard the first $65 of the monthly self employment income and one-half of the remaining self-employment income.

Some farmers report not having enough income to file federal income tax. Federal farm program payments are reported to IRS (Internal Revenue Service) on a 1099. Therefore, an IRS representative advises that farmers would file an IRS 1040 so that IRS knows why no tax was due for the year. The farmer or rancher may have a negative taxable income after personal exemptions and other deductions are made. The figure required on the SFN 820 is the "Adjusted Gross Income," the last line on the first page of the IRS 1040; not the taxable income shown on the back. The farmer or rancher, as operator or as renter, must have federal tax forms.

For an applicant/client having rental farm property, the net income on IRS form 4835 is entered on the front page of the 1040. That is the amount reported on the SFN 820 divided by 12 months.

For the applicant/recipient reporting income or loss as operators of their farm or ranch, the amount is determined by use of IRS Schedule F. That is the amount entered on SFN 820 after dividing by 12 months.

If a family member is paying room and board for the recipient who resides in an Adult Foster Care home you do not need to count the amount of room and board paid as income if the payment is made directly to the provider. If the money is paid or deposited directly to the recipient it must be counted as income.

Payment from reverse mortgages is not counted if it is a type of reverse mortgage that needs to be repaid unless, the amount of the reverse mortgage results in a profit for the recipient and or the recipient's spouse. If they receive a payment in excess of the value of the home it would be counted as income.

Income received by the recipient or the recipient's spouse as the result of a community benefit, go fund me account etc. will be considered countable income unless the money is deposited ~~in to~~ into an account that is managed by a 3rd party. Countable income may be calculated by dividing the total amount received /12 months to get a monthly average.

In addition to completed IRS tax forms, include the following:

B	Wages, Salaries – record the wages and salaries found from income tax documentation, federal tax form 1099, and/or federal tax form W2. If the individual does not file taxes or has limited wages or salaries and tax documentation is not required, copies of checks or receipts may be used.
B3	Veterans Benefits – include all benefits including Aid & Attendance unless counting Aid and Attendance as income will have a negative effect on an individual’s eligibility for SPED. In that case,

	you can deduct the amount of Aid and Attendance the individual receives from the amount of SPED services being authorized. If a veteran is unsure of the amount of Aid and Attendance payment included in their veteran's pension, contact the county veteran's office to obtain the information.
B4	Social Security, SSI, Disability Income. Note that if an individual is eligible to collect Social Security benefits and they choose not to collect, the amount they should receive still needs to be counted and considered income. If the amount is not known, the average amount of Social Security in North Dakota will be counted as income. SPED considers income an individual is eligible to receive as countable income regardless of whether they elect not to receive the income.
B5	Dividends, Interest – found from financial accounts from financial institutions or could include interest paid to the applicant/client from a loan or sale of property/goods.
B6	Estates, Trusts, Net Rentals, Royalties, Income produced by real property (land) is also included here. While real property (land) is not included as an asset except in the case of a non-primary residence, income that is received or should be received from land needs to be counted as income.
B7	Pensions, Annuities
B8	Temporary Aid for Needy Families
B9	County General Assistance
B12/B13	Self-Employment Income
B2/B10/B11/B14	Combine alimony/child support/unemployment compensation/Workers Compensation/ and other

Disregards to Income

1. Compensation or stipends received by volunteers participating in Senior Community Service Employment Program (formerly known as the Green Thumb project or Experience Works) or Senior Companion;

2. Income earned or unearned by dependent children;

3. Income earned of adult children caring for parent(s);

4. The family home care payment if the spouse is the family home care provider;

5. The conversion of one asset form to another form may not be considered income.

   Example 1: A house is sold for cash. The cash would not be considered income but would be considered additional liquid assets.

   Example 2: Cash is converted to a CD. The CD is considered as a liquid asset, but now the interest generated from the CD would be income. If a client has made the choice to reinvest the interest by having the interest increase the value of the CD or saving account, the interest is to be considered as income in the month in which the client could have accessed the dividend or interest.

6. Any amount of funds held in a restricted or unrestricted IIM account, as well as per capita distributions.

7. Recovery Rebates authorized by section 2201 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 [Pub. L. 116-136].

8. Money payments made by the Department, another state, or tribal entities in connection with the State LTC Subsidy program, foster care, subsidized guardianship, or the subsidized adoption program.

Section 2: DEDUCTIONS TO INCOME

Deduct the following monthly expenses to determine the family adjusted gross monthly income:

C1 Child Support Payment For Child(ren) Not Claimed As Dependent(s)

C2 Medical Deductions, a medical deduction of up to $850 for a family or $500 for an individual is allowable for any medical/accident insurance paid by the individual AND any regular payment (out of pocket) for medical expenses. Medical expenses do not include prescription drugs. If the individual is a recipient of Medicaid or Economic Assistance programs, the information has already been verified and is on file with the Eligibility Specialist. In these cases, the case manager can cross reference those files.

Medical expenses include, but are not limited to, the following items, which must be paid for either in part or full by the client:

- Health/accident insurance: insurance premium, Medicare Part B payment, coinsurance, and deductibles on health plans.
- Medical services by a licensed medical facility or professional
- Supplies for incontinence (e.g. Depends, Chux, et cetera)
- Adaptive Devices such as wheelchairs, crutches, eyewear
- Medical Transportation costs: bus, taxi, train, or plane fares; actual care expenses such as gas and oil or 65 cents a mile; and parking fees and tolls.
- Long term care premiums
- Over the counter medications (non-prescription) that a medical professional has directed the client to take for a specific medical condition. The client will need to obtain a written recommendation from a medical professional for the over the counter medication, and it must relate to a specific health condition.
- Private pay personal care services (would not include SPED service fee).

C3 Child Care Expenses paid Because Of Employment

C4 Alimony (Paid)

C5 Prescription Drugs -- For out of pocket prescription drugs deductions, the drugs must be verified and the information recorded in the Deduction Detail section (unless can cross reference with eligibility specialist). Medical marijuana is considered a prescription drug for which out of pocket payments can be deducted if the individual provides verification of a valid registry identification card, and items purchased can be verified via receipts from a North Dakota registered compassion center dispensary.

Upon completion of the document, the client will sign signifying they have provided ~~the county with~~ all information required to meet SPED financial eligibility. The individual should not sign the document until the verification process has been completed.

The "For Office Use Only" section is for case managers to assess the client service fees based on the sliding fee schedules, sign, date, and designate documentation is on file.

Also in this section, the case manager will record the "Number of Individuals" in the household. This number should only contain those persons counted in the official household count. When determining SPED financial eligibility, individuals to be included in a household count if residing together, include the recipient/applicant of services, spouse of the recipient/applicant, children and stepchildren under the age of 18 of the recipient/applicant, and any other individual that has been designated as a ward or dependent person of the applicant/recipient or the spouse by court order.

The form, SFN 820, is not available from the Department. HCBS Case Managers are required to make sufficient copies for their use. The form is available electronically through the state e-forms system.

Overpayment

If there are credible allegations that an individual or their legal representative concealed or misrepresented financial or functional

information with the purpose of obtaining eligibility for HCBS, the Department may recoup the overpayment.