Par. 1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 585-05, Home and Community Based Services. New language is in red and underlined and old language has been struck through.

Standards for Qualified Service Provider(s) 525-05-45

Provider Enrollment

Purpose

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

Legal Authority

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

Century Code 50-11-02.4

Century Code 50-11-06.8

Century Code 50-11-06.9

N.D. Admin. Code 75-03-23-07

N.D. Admin. Code 75-03-23-08

N.D. Admin. Code 75-03-23-10

N.D. Admin. Code 75-03-21-08

Standards for Qualified Service Providers

1. Qualified Service Provider (QSP) must be 18 years of age.
2. Must meet the standards of CFR Part 455-Program Integrity Medicaid.
3. Must meet the provider standards and agreements according to the N.D. Admin. Code and CFR.

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

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

Standards for Qualified Service Providers for Environmental Modification

- Environmental Modification Service may only be provided by a contractor approved by the Department of Human Services as a Qualified Service Provider. Standards for Qualified Service Providers of Environmental Modification Service are as follows:

    - Building contractors must have a current North Dakota Contractor's license, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance. Show verification of an appropriate building permit.

    - Electricians must be licensed by the North Dakota State Electrical Board, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance.

    - Plumbers must be licensed by the North Dakota State Plumbing Board, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance.

    - All licensed contractors must provide a copy of their registration with the Secretary of State; provide a copy of their license, proof of

liability insurance/bonding, and proof of enrollment and good standing with Workforce Safety and Insurance. These documents must be submitted with the request to be a Qualified Service Provider (QSP).

Standards for Home Delivered Meal Providers

- Enrolled as an individual or agency Qualified Service Provider;
- Licensed as a food establishment pursuant to NDCC 23-09, Hospital, nursing facility, basic care facility; or contracted with Aging Services Division as an OAA Nutrition Provider;
- Meet all applicable federal, state, and local laws and regulations regarding the safe and sanitary handling of food, equipment, supplies and materials used in storage, preparation, and delivery of meals to eligible recipients pursuant to the ND Requirements for Food and Beverage Establishments (NDAC 33-33-04).
- Providers licensed as a Hospital must also meet standards pursuant to NDCC 23-16, NDAC 33-07-01.1, & NDAC 33-07-02.1
- Providers licensed as a nursing facility must also meet standards pursuant to NDCC 23-16 & NDAC 33-07-03.2 & NDAC 33-07-04.2
- Providers licensed as basic care must also meet standards pursuant to NDCC 23-09.3 & NDAC 33-03-24.1

Provider Enrollment Limitations

1. All verification screenings required by the federal and state laws, rules, or regulations must be complete before enrollment can be finalized.
2. The enrollment effective date cannot be prior to the required verification screening date.
3. Effective enrollment date of QSP for services of Family Home Care or Family Personal Care may not be prior to client/member's signature on care plan.
4. A Monthly Rate Worksheet SFN 1012 must be sent to the QSP provider enrollment Program Administrator before final approval of QSP for Family Home Care or Family Personal Care will be granted.
5. If enrollment is not complete by the end of the 30 day notice period, the QSP status will be stopped and a new start date will be given if/when a complete application is received and approved.

6. Any break in licensure or documentation of competency dates will result in a stop and new start date.
7. A break in renewal status greater than 30 days from the QSP closed date will result in a stop and a new start date and a complete application will be required. (This is due to the monthly renewal verification checks not being completed as required)

Provider Reimbursement Limitations

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

Enrollment Process for New Applicants

1. All forms must be completed and done correctly, along with the verification checks by the HCBS Program Administrator before an enrollment start and end date will be given (dates cannot be retroactive).
2. The following provider verifications must be completed by the HCBS Program Administrator according to the CFR and state regulations:

    - Verification of current competency, certification, or licensure and good standing in state
    - List of Excluded Individuals and Entities (LEIE)(OIG)
    - Excluded Parties List System (SAMS) Previously (EPLS)
    - National Sex Offender Site
    - ND Sex Offender Site
    - Child Abuse and Neglect Background Inquiry
    - Check Termination and Denial list
    - Check Certified Nurse Assistance Abuse list
    - Health Market Science (HMS) or Accurint check which includes the following:
        - OIG (Office of Inspector General)
        - State Medicaid Exclusion
        - Social Security Administration Death Master File
        - National Plana and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
        - DEA (Drug Enforcement Administration)

- Addresses

3. QSP will be issued an "enrollment end date" no longer than 24 months from the date of enrollment.
4. Enrollment end date may be up to 23 months from original competency date to allow sufficient time for renewal.

Enrollment Process for Family Home Care and Family Personal Care

1. All forms must be completed correctly and the required verification checks by the HCBS Program Administrator must be complete before an enrollment start and end date will be given.
2. The following provider verifications must be completed by the HCBS Program Administrator according to the CFR and state regulations:

   - Verification of current competency, certification, or licensure and good standing in state
   - List of Excluded Individuals and Entities (LEIE)(OIG)
   - Excluded Parties List System (SAMS) Previously (EPLS)
   - National Sex Offender Site
   - ND Sex Offender Site
   - Child Abuse and Neglect Background Inquiry
   - Check Termination and Denial list
   - Check Certified Nurse Assistance Abuse list
   - Health Market Science (HMS) or Accurint check which includes the following:
     - OIG (Office of Inspector General)
     - State Medicaid Exclusion
     - Social Security Administration Death Master File
     - National Plana and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
     - DEA (Drug Enforcement Administration)
     - Addresses

3. Family Home Care does not require documentation of competency.
4. Family Personal Care requires that a valid proof of competency be sent with the application.
5. Effective enrollment date of QSP enrollment for the services of Family Home Care or Family Personal Care may not be prior to the date of the client/member's signature on the care plan.
6. A monthly rate worksheet must be sent to the QSP provider enrollment Program Administrator before final approval of QSP for Family Home Care or Family Personal Care will be granted.

7. A start date will be determined by reviewing:
    - The completed application;
    - Provider screening verification date;
    - Client approval date for service;
    - Client/member signature on care plan and;
    - Monthly Rate Worksheet.
8. QSP will be issued an "enrollment end date" no longer than 24 months from enrollment.
9. Enrollment end date may be up to 23 months from original competency date for family personal care or the date of signature on the Medicaid Agreement for family home care, to allow sufficient time for renewal.

Enrollment Process for Renewals

1. All forms must be completed correctly, and the required verification checks by the HCBS Program Administrator must be complete before renewal of QSP status can be approved.
2. The following provider verifications must be completed by the HCBS Program Administrator according to the CFR and state regulations:

    - Verification of current competency, certification, or licensure and good standing in state
    - List of Excluded Individuals and Entities (LEIE)(OIG)
    - Excluded Parties List System (SAMS) Previously (EPLS)
    - National Sex Offender Site
    - ND Sex Offender Site
    - Child Abuse and Neglect Background Inquiry
    - Check Termination and Denial list
    - Check Certified Nurse Assistance Abuse list
    - Health Market Science (HMS) or Accurint check which includes the following:
        - OIG (Office of Inspector General)
        - State Medicaid Exclusion
        - Social Security Administration Death Master File
        - National Plana and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
        - DEA (Drug Enforcement Administration)
        - Addresses

3. QSP is given an "enrollment end date" no longer than 24 months from enrollment.
4. Enrollment end date may be up to 23 months from original competency date to allow sufficient time for renewal.

5. Six to eight weeks prior to the end date, the QSP will be sent a renewal application.
6. If renewal is not received by the renewal end date, the QSP and the HCBS Case Manager and/or the DD Program Manager will be sent a written notification of a 30 day stop notice period, allowing the provider 30 extra days to renew.
7. If renewal is not received and processed during the 30 day stop notice period, the QSP must be taken off the care plan.
8. QSP wishing to continue to provide care must have a complete application submitted and approved before. (*There will be no retroactive dates after the 30 day notice).*

Exceptions

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

Provider Addresses

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

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

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

30 Day Stop Notice

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

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

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

Stop and Start dates

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

Closure for Inactivity

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

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

15 minute unit rates

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

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

2 units: at least 23 minutes	6 units: at least 83 minutes
3 units: at least 38 minutes	7 units: at least 98 minutes
4 units: at least 53 minutes	8 units: at least 113 minutes
5 units: at least 68 minutes	

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

Monthly Rate Worksheet - Live-in Care, SFN 1012 525-05-60-65

Purpose: The Monthly Rate Worksheet, SFN 1012, is used by the Case Manager to determine the daily rate of payment for live in, 24 hour care. This is to be completed and forwarded to Medical Services/HCBS on an annual basis regardless of a change.

SECTION I: IDENTIFYING INFORMATION

Complete the individual's name, the Case Manager's name, date the assessment is completed, individual's county of residence, the individual's recipient identification number, the effective date of the rate as determined on the rate worksheet, and the individual's date of birth.

> Note: Any change in the rate becomes effective the first day of the following month. For example, if the Monthly Rate Worksheet is completed based on an assessment dated April 12, 2006, the rate change becomes effective with services delivered beginning May 1, 2006.

Medicaid Waiver Person Centered Plan of Care, SFN 404 525-05-60-105

Purpose:

The Person Centered Plan of Care (SFN 404) is a summary of the needs and service options identified in the assessment process and is an outline of the plan developed by the client, Case Manager and others to meet the client's needs.

When Prepared:

The Person Centered Plan of Care is required for all clients receiving HCBS Case Management/ Services under the Medicaid Waiver(s). It is to be revised or updated as client's needs warrant. It is to be reviewed with the client at the annual/six-month review, and complete a new form if necessary due to changes in service(s) and/or amounts. Quarterly visits to the client are required with a follow-up note within the narrative in SAM's.

Six month reviews: during client visit CM must complete a new front page listing services and new section VII to include new signatures. Cm may copy section X –Risk Assessment and Section VI – Restrictions from annual plan. CM adds date of 6 month visit to these sections and completed bottom portion of the Section VI. All pages are then sent to the department within 3 days of completed plan.

The Person Centered Plan of Care must be revised when a change occurs (unless it is a result of legislative action).

Section I Client Identification:

Enter the name, physical address, client identification number, county of residence, county code, and effective date of screening of level of care.

Section II Approved Services:

If receiving Rural Differential Rate (determined under Rural Differential policy 525-05-38) mark the correct tier (RD 1, 2, or 3) for rate.

HCBS/TD Waiver ☐ RD1 ☐ RD2 ☐ RD3 ☐ RD Removed

When marking RD Removal a SFN 212 is required to be sent to the department.

Column Headings:

1. SERVICE: Enter the service that has been identified for which the client is eligible, and the client has accepted.
2. SERVICE PROVIDER: Identify the qualified service provider (agency or individual) who will provide the service
3. PROVIDER NUMBER: Enter the provider's number
4. UNIT RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate

a. If RD box was marked – rate should match rates determined within Rural Differential policy. (Total rate cost may be over cap however units should match cap: example: 70 units' individual or 50 units' agency cap out Homemaker services.)

b. If removal of Rural Differential is required: make the box "RD removed" and write the end date by QSP name being removed from RD, cross off RD rate and write correct rate. Complete SFN 212.

5. UNITS PER MONTH: Enter the total number of units of service to be provided per month.

6. COST/MONTH: The cost per month is calculated based on the amounts in the columns headed "Unit Rate," and "Units per Month" (based on a 31-day month).

Case Management has been pre-entered on the form. The Service Provider, Provider Number, and Unit Rate must be entered by the Case Manager.

Total Cost: The total per month costs of services is the total to be reimbursed under the Waivers. The Grand Total does NOT include the cost of HCBS Case Management. When authorizing services by unit and or daily rate the maximum amount must not exceed on the program and/or service cap.

Section III: ADL's & IADL's

ADL's & IADL's Scores: must be added from the Functional Assessment scoring.

Section IV: Contingency Plan

The Contingency Plan must be completed. Name of person assisting with meeting contingency plan must be listed along with phone number to be reached at.

Section V: Signatures

The client/legally responsible party must check all applicable boxes acknowledging agreement and or awareness of the specific information.

The signature of the client/legal representative and HCBS Case Manager is required. Any other person attending the Person Centered planning must sign here as an other.

If legal representative is not present in-person the plan is not complete and will not be able to have effective dates entered until signature has been received. Effective date of plan could either start on date of legal representative's signature or a future date.