Par. 1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 535-05, Medicaid State Plan – Personal Care Service. New language is in red and underlined and old language is in red and has been struck through.

Par. 2. **Effective Date** – 5/1/2025

Definitions 535-05-10
(Revised ~~04/01/2025~~ 05/01/2025 ML#~~3911~~ 3915)

Activities of Daily Living (ADLs)

Tasks of a personal nature that are performed daily which involves such activities as bathing, dressing, toileting, transferring from bed or chair, continence, eating/feeding, and mobility inside the home.

Agency - Qualified Service Provider (QSP)

An agency that enrolls with the department as a Qualified Service Provider, which allows that agency to bill the department for services rendered. Agency providers can include Department of Health and Human Services, Human Service Centers, and County Social Service Boards.

Aging Services Section

A Section within the Department of Health and Human Services (DHHS) within the Program and Policy's organizational structure with administrative and programmatic responsibility for Home and Community Based Services (HCBS).

Applicant

An individual making application for services. An applicant may have a legal representative seeking services on behalf of the individual.

Basic Care Assistance Provider (BCAP)

An entity that is licensed as a basic care facility; is not owned or administered by state government; does not specifically provide services for individuals with traumatic brain injury or Alzheimer's disease or related dementia; and is enrolled with the Department as such.

Comprehensive Assessment
Instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, household members, emergency contacts, medical resources, health care coverage, and source and reason for referral, and to secure measurable information regarding: physical health, cognitive and emotional functioning, activities of daily living, instrumental activities of daily living, informal supports, need for twenty-four hour supervision, social participation, physical environment, financial resources, and other information not recorded elsewhere.

Critical Incident Report (CIR)

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of any client receiving HCBS.

Department

The North Dakota Department of Health and Human Services (DHHS).

Dependent

Any individual who the applicant/client is legally responsible to provide support and care: minor child, spouse, anyone placed in the care of the applicant/client by court order.

Endorsements

A task that requires special skills and approval.

Developmental Disabilities Section

A Section within the Department of Health and Human Services (DHHS) within the Program and Policy's organizational structure with administrative and programmatic responsibility for Home and Community Based Services (HCBS) for Individuals with Intellectual Disabilities and Developmental Disabilities (IID/DD).

Developmental Disabilities Program Manager (DDPM)

Employee of the Department of Health & Human Services (state Medicaid agency) responsible to provide coordination and monitoring of Medicaid and general fund services provided to individuals with intellectual and/or developmental disabilities. The DDPM is a case manager.

Exploitation

The act or process of an individual using the income, assets, or person of another individual for monetary or personal benefit, profit, gain, or gratification.

Family Member

Defined as 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. Current or former spouse refers to in-law relationships.

Functional Assessment

An instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, individuals residing with, emergency contacts, medical resources, health care coverage, and source and reason for referral; and to secure measurable information regarding

a. Physical health;
b. Cognitive and emotional functioning;
c. Activities of daily living (ADLs);
d. Instrumental activities of daily living (IADLs);
e. Informal supports;
f. Need for twenty-four-hour (24) supervision;
g. Social participation;
h. Physical environment·
i. Financial resources;
j. Adaptive equipment;
k. Environmental modification; and
l. Other information about the individual's condition not recorded elsewhere.

Functional Impairment

The inability to perform, either by oneself or with adaptive aids or with human help, specific activities of daily living or instrumental activities of daily living.

HCBS Program Administration

A unit within Adult and Aging Services. HCBS Program Administration includes the programs of Targeted Case Management, Medicaid Waiver Home and Community Based Services, Medicaid State Plan Personal Care, Service Payments for the Elderly and Disabled, and Expanded Service Payments for the Elderly and Disabled.

Home and Community-Based Services (HCBS)

The array of services under the SPED program and Medicaid Waiver defined in the comprehensive human service plan and the other services the department determines to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care.

Homemaker

An individual who meets the standards and performs tasks/activities under the provisions of this service chapter.

Homemaker Service (HMK)

Provision of non-personal (environmental) care tasks such as light duty housekeeping, laundry, meal planning and preparation, and shopping that enables the individual to maintain independence.

Individual – Qualified Service Provider (QSP)

An individual who enrolls with the department as a Qualified Service Provider, which allows that individual to bill the department for services rendered.

Institution

Institution means an establishment that makes available some treatment or

services beyond food or shelter to five or more persons who are not related to the proprietor. N.D.C.C. 50-24.05-01(8).

Instrumental Activities of Daily Living (IADLs)
Includes complex life activities routinely performed by an individual such as housework, laundry, meal preparation, taking medication, shopping, outside mobility, transportation, management of money, and use of a telephone.

Legally Responsible Person

Legal spouse or parent of a minor child.

Legal Representative

Someone who has been given power by law to represent another person.

Level A Personal Care Services

The level of care for an individual meeting the minimum eligibility criteria for personal care services.

Level B Personal Care Services

The level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to the minimum eligibility criteria for personal care services.

Level C Personal Care Services

The level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to having an impairment in 5 ADLS.

Level-of-Care (LOC) Determination

A medical screening requested to determine eligibility for the Medicaid Waivers, Medicaid State Plan Levels B & C, or to screen children for the SPED program. The Department contracts with a utilization control management team to establish medical need.

Long Term Care Need

A need for the services available under the SPED Program, ExSPED Program, Medicaid Waiver Program, or the Medicaid State Plan Personal Care Option that is be anticipated to exceed 90 days.

Medical Services Division

A Division within the department with administrative responsibility to enroll Qualified Services Providers, conduct Qualified Service Provider audits, and set rates for HCBS services.

Medicaid State Plan Personal Care Program (MSP-PC)

Personal care services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), so that the individual is able to live at home. See MSP-PC Policy Manual (535-05).

Monitoring

Overseeing and periodically reviewing the individual's progress, condition, and the quality and quantity of services provided.

Most Integrated Setting

A setting that enables an individual with a disability to interact with non-disabled persons to the fullest extent. The most integrated setting for an individual will usually be a private residence owned or rented by the individual or their family member.

Natural Supports

An informal, unpaid caregiver that provides care to an applicant or client.

Neglect

The failure of an individual to provide the goods or services necessary to avoid physical harm, mental anguish, or mental illness.

Nursing Facility (Long Term Care Facility)

A facility licensed by the North Dakota Department of Health and Human Services and Consolidated Laboratories to provide residential nursing and medical care.

Parent

A child's adoptive or biological mother, or father, or stepparent who has legal responsibility for a child.

Personal Care Service Provider

A qualified service provider or a basic care assistance provider.

Personal Care Services

Services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands-on assistance or cuing so that the individual can perform a task without direct assistance.

Private Family Dwelling
A private residence intended for long-term occupancy, such as a house, apartment, or camper-provided the camper is located in a long-term campground (e.g., rented by the month or year). Meals may be prepared and consumed on-site, provided through a congregate setting, or eaten off-site.

In unique or uncertain situations, please consult the HCBS Program Administrator for further guidance.

Qualified Service Provider (QSP)

An individual or agency that has met all of the standards/requirements and has been designated by the department as a provider.

Qualified Service Provider (QSP) Handbook

A handbook outlining the standards and procedures required for agencies and individuals to qualify as a Qualified Service Provider.

Service Payment

The payment issued by the Department to the caregiver/qualified service provider.

Settings Rule

Centers for Medicare & Medicaid Services (CMS) issued a final rule that requires states to review and evaluate HCBS settings. States are required to ensure all HCBS settings comply with the new federal requirements to ensure that all individuals receiving HCBS are integrated in and have full access to their communities.

Sexual Abuse

Conduct directed against an individual which constitutes any of those sex offenses defined in N.D.C.C. 12.1-20-02, 12.1-20-03, 12-1.20-04, 12.1-20-05, 12.1-20-06.

Social History

Components of Social History include: Demographics, Who lives in the Home, Health History, Family Structure, Coping Mechanisms, Support System, Educational and Employment History, Behavior/Psychological/Social Information, Financial Resources, Identification of Service Need, and Outcome of Services Provision.

Supervision

Up to 24 hours of supervision may be provided to eligible individuals who because of their disability need monitoring to assure their continued health and safety.

Vulnerable Adult

An adult who has substantial mental or functional impairment.

Vulnerable Adult Protective Services (VAPS)

Addresses the safety of vulnerable adults who are at-risk of harm due to the presence or threat of abuse, neglect, or exploitation.

Unit

Either a 15-minute increment or a day.

Vulnerable Adult Protective Services (VAPS) Report

Any person who reasonably believes that a vulnerable adult has been subjected to abuse or neglect or observes conditions or circumstances that reasonably would result in abuse or neglect must report the information to the department or to an appropriate law enforcement agency.

Personal Care Eligibility Requirements 535-05-15
(Revised ~~10/01/2024~~ 05/01/2025 ML #~~3871~~ 3915)

An individual wishing to apply for benefits under this chapter must have the opportunity to do so, without delay. The HCBS case manager/DDPM must schedule an appointment for an initial assessment no later than five working days after receiving a request for services and must complete an initial comprehensive assessment no later than ten working days after receiving a request for services. All contacts with an individual must be documented within the narrative in the web-based data collection system.

1. Application for services in service chapter shall be made to the department utilizing "Application for Services," SFN 1047.
   a. An application is a request made to the department or its designee by individual seeking services under this chapter, or by an individual properly seeking services on behalf of another individual. "An individual properly seeking services" means an individual of sufficient maturity and understanding to act responsibly on behalf of the individual for whom services are sought.
   b. The case management entity must accept a referral from an individual who is acting in the best interest of the client and cannot require that the client themselves to actually make the initial request for services. However, the actual applicant must agree to a home visit.
   c. The applicant or their legal representative must sign the application and participate in the eligibility process.
   d. The department or its designee shall provide information concerning eligibility requirements, available services and the rights and responsibilities of applicants and recipients to all who require it.
   e. The date of application is the date the department's designee receives the properly signed application.

   The applicant shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age, identity, residence, blindness, disability, functional limitation, financial

eligibility, and other information required under this chapter.

2. An applicant is eligible for these programs if the Case Management process (comprehensive assessment of needs and care plan development) determines that the applicant meets functional and financial eligibility criteria for MSP PC and requires those tasks/activities allowable within the scope of the services. An initial functional assessment, using the form required by the department, must be completed as a part of the application for benefits under this chapter. A functional assessment must be completed at least annually, and reviewed every 6 months, in conjunction with the eligibility redetermination. The functional assessment must include an interview with the individual in the home where the individual resides unless approval is given to interview the individual in an alternative setting.
3. Authorization to Provide Services, otherwise known as the PreAuth, identifies the specific tasks/activities the provider is authorized to perform for the eligible client and sets forth the scope of the service the client has agreed and understands will be provided.
4. The client is eligible for MSP PC once all eligibility criteria have been met. Continued eligibility is monitored under HCBS Case Management/DD Program Management. At any time there is a question as to whether the client continues to meet functional or financial eligibility criterion, the HCBS case manager/DDPM is to substantiate eligibility.

To qualify for coverage of personal care services, an individual must live in what is commonly considered a private family dwelling or Licensed Basic Care Facility and currently be open to receive Medicaid benefits under traditional Medicaid or receive Medicaid Expansion and be deemed Medically Frail.

And

1. Eligibility criteria for **Level A (up to 480 units per month), or Daily Rate care, or Basic Care** includes:

    a. Be impaired in at least one of the following ADLS of:

        i. Bathing
        ii. Dressing

iii. Eating
iv. Toileting
v. Continence
vi. Transferring
vii. Inside Mobility

Or

b. Be impaired in at least THREE of the following IADLs:

i. Meal Preparation
ii. Housework
iii. Laundry
iv. Taking medications

2. Eligibility for **Level B (up to 960 units per month)** includes:

a. Be impaired in at least one of the following ADLS of:

i. Bathing
ii. Dressing
iii. Eating
iv. Toileting
v. Continence
vi. Transferring
vii. Inside Mobility

Or

b. Be impaired in at least THREE of the following IADLs:

i. Meal Preparation
ii. Housework
iii. Laundry
iv. Taking medications

AND

c. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

3. Eligibility for Level C (up to 1200 units per month) includes:

a. Be impaired in at least five of the following ADLS of:
   i. Bathing
   ii. Dressing
   iii. Eating
   iv. Toileting
   v. Continence
   vi. Transferring
   vii. Inside Mobility

   AND

b. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

   AND

c. None of the 300 hours (1200 units) approved for personal care services can be allocated to the tasks of laundry, shopping, or housekeeping.

   ~~AND~~

~~d. Have written prior approval for this service from a HCBS Program Administrator, Aging Services, Department of Health and Human Services. The approval must be updated every six months.~~

The functional assessment measures the degree to which an individual can perform various tasks that are essential to independent living. Information on each of the ADLs or IADLs can be collected by observation, by direct questioning of the individual, or by interview with a significant other. The case manager shall maintain documentation supporting the level of impairment and shall include the following information if applicable:

1. Reason for inability to complete the activity or task
2. Kind of aid the individual uses (e.g., a grab bar or stool for bathing)
3. Kind of help the individual requires (e.g., preparing the bath, washing back and feet, complete bed bath) and the frequency of the need to have the help (e.g. units of services needed)
4. Who provides the help

5. The individual's health, safety and welfare needs that need to be addressed
6. Document the anticipated outcome as a result of service provision
7. Other pertinent information

Limitations and Non-covered Services 535-05-25
(Revised ~~10/01/2024~~ 05/01/2025 ML #~~3871~~ 3915)

1. Personal care services may not include skilled services performed by persons with professional training.
2. An individual receiving personal care services must live in a private family dwelling or licensed Basic Care facility, and may not be an inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental disease.
3. Personal care services may not include home delivered meals; services performed primarily as housekeeping tasks; transportation; social activities; or services or tasks not directly related to the needs of the individual such as doing laundry for family members, cleaning of areas not occupied by the individual, or shopping for items not used by the individual.
4. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housework tasks when provided must be incidental to the provision of other personal care tasks and cannot exceed 30% of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.
5. Services provided by a spouse, parent of a minor child, or legal guardian are not covered.
6. The tasks of laundry, shopping, housekeeping, meal preparation, money management and communication may be assessed for individuals whose provider is a relative listed under the definition of family home care under subsection 4 of the North Dakota Century Code section 50-06.2 02 or who is a former spouse beginning at the first required contact after 1/1/2021. Conditions that would benefit the consumer would include, but are not limited to, maintenance of

the home environment, such as shared spaces as assigned by the case manager and individual's laundry.

7. Care needs of the individual that are outside the scope of personal care services are not covered.
8. Services provided in excess of the services or hours authorized by the case manager in the individual's approved care plan are not covered.
9. Authorized personal care services may not exceed 120 hours (480 units) per month for Level A Personal Care Services or 240 hours (960 units) per month for Level B Personal Care Services, and 300 hours (1200 units) per month for Level C Personal Care Services.
10. Personal care services may be provided to a recipient who has natural supports. For purposes of this subsection, "natural supports" means an informal, unpaid caregiver that provides care to an applicant or recipient.
11. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.
12. Per guidance given by the Centers for Medicare and Medicaid Services in the following 2001 HHS Survey and Certification memo, personal cares can be offered in conjunction with Hospice services.

    https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/SurveyCertificationGenInfo/downloads/SCLetter01-013.pdf

13. The combination of personal care services and hospice service requires approval from the Department. The request must outline the individual's needs, the services that will be provided through Hospice, and the services being requested through MSP PC. The request must also contain an assurance that there is not a duplication of services.
14. The Hospice plan of care must include the need for personal care services and a copy must be maintained in the individual's file.

Management 535-05-35
(Revised ~~10/01/2024~~ 05/01/2025 ML #~~3871~~ 3915)

Case management for an individual applying for or receiving personal care services shall be the responsibility of an HCBS case manager except when the individual is also receiving a service(s) through the Developmental Disabilities section. Case management for personal care services for an individual receiving a service(s) through the DD section shall be the

responsibility of a DD Program Manager (DDPM). If the individual is not receiving service(s) through the Traditional IID/DD HCBS Waiver, they have the right to choose the provider of case management services.

The case manager is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual with obtaining a personal care service provider, monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

Part of completing an assessment includes determining an individual's overall support needs, whether the supports will be provided through HCBS or through other community resources. 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, for example, case managers can share individual information with health care professionals working in the 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.

Decisions regarding personal care services for an incapacitated individual are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

The case manager must schedule an appointment for an initial assessment no later than 5 working days after receiving a request for personal care services and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for personal care services. All contacts with an individual must be documented in the case file.

An application for services must include a complete functional assessment that was conducted with the individual in the home where the individual resides by an HCBS Case Manager/DDPM. A comprehensive assessment must be completed initially and annually thereafter for the individual or if there has been a significant change in personal care needs. The comprehensive assessment must include information on the individual's physical health, cognitive and emotional functioning, ability to perform activities of daily living or instrumental activities of daily living, informal supports, need for 24 hour supervision, social participation, physical environment, financial resources, and any other pertinent information about the individual or his/her environment.

Individuals must actively participate in the functional assessment to the best of their ability. Case Managers must document in the individual narrative if there is a medical reason why the individual cannot participate in the assessment or answer questions directly. If a third party (including family) reports that the individual cannot participate in the assessment but the case manager questions if this information is accurate you may request medical documentation to confirm that the individual is not capable of participating before you can establish eligibility. It is the responsibility of the individual to provide all information necessary to establish eligibility per NDAC 75-03-23-15. Proof of blindness, disability and functional limitation may include but is not limited to complying with all requests for medical records or an evaluation from PT, OT, Speech, neuro-psych evaluation etc. that would assist the case manager in completing a determination for HCBS services.

After completing the comprehensive assessment, the case manager and individual work together to develop a person-centered plan of care based on the individual's needs, situations, and problems identified in the assessment. The plan must include:

1. All problems identified, including those that will not be addressed through the provision of personal care services.
2. Desired outcome(s) for each problem must be documented in the

comprehensive assessment for which units of personal care services have been authorized.
3. The type(s) of help needed to achieve each desired outcome.
4. Services and providers that can supply the need for help.
5. Provider(s) the individual selects.
6. The amount of personal care service to be provided and the specific time-period.
7. Documentation of the medical necessity to monitor vital signs and identify who is to be notified of an individual's vital signs readings.

The case manager shall identify personal care service providers available to provide the service required by the individual and provide the following information to the individual:

1. Name, address and telephone number of available personal care service providers.
2. Identify whether a provider is an agency or individual QSP or a basic care assistance provider.
3. Any limitations applicable to the available providers.
4. If applicable, any global or individual specific endorsements for specialized cares that available providers are qualified to perform.

The individual must select the personal care service provider(s) they want to deliver the service to meet their care needs. The case manager must then complete a person-centered plan of care and preauth for services provided within the community-setting or the SFN 662 for personal care services by a basic care provider.

The case manager must monitor and document that the individual is receiving the personal care services authorized on the preauth. The case manager must review the quality and quantity of services provided. A reassessment of the individual's needs and care plan must be completed at a minimum of six-month intervals. The case manager shall visit with an individual in his/her place of residence every six months and review and update the assessment and the individual's care plan as necessary.

A quarterly face-to-face visit is required for consumers receiving services under Level C. At each quarterly contact, the case manager will monitor the quality, quantity and frequency of services, assess and/or review any risks, and monitor all health/welfare/safety concerns. A narrative must be completed for each quarterly contact.

The State Medicaid Agency may waive the face to face requirement for case management services, based on specialized health care situations that may require a recipient to be out of state for other medical services. Any waiver of this requirement will require special approval from the Aging Services HCBS Program Administrator for Aging Services program participants or DD Residential and Vocational Services Administrator for DD program participants.

The case manager is responsible for following Department established protocols when abuse, neglect or exploitation of an individual is suspected.

Standards for Targeted Case Management (TCM) for persons in need of Long term Care.

- The service shall be performed by a social worker or agency who employs individuals licensed to practice social work in North Dakota and who has met all the requirements to be enrolled as either an Individual or 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 Disability Professional (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 Disability Professional (QDDP) or has one year experience as a DDPM with the Department.
- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.
- 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 MSP-PC Service:

- Case Managers employed by Aging Services.
- Developmental Disabilities Program Managers (DDPM)

    - 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, enrolled Individual or Agency Case Managers 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 be covered under any other 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 reside 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 ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.

6. Has "long-term care need." 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.
1. 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-Care Plan Development

3-Referral and Related Activities

4-Monitoring and Follow-up Activities

- The focus or purpose of TCM is to identify what the person needs to remain in their home or community and be linked to those services and programs.
- An assessment must be completed and a Care Plan developed. The individual's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System or the THERAP System/MSP-PC Functional Assessment.
- Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The individual must be informed of that fact by noting Case Management Service and cost on the Individual Care Plan. Individuals must also check and sign acknowledgment that if they are on Medicaid they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are subject to estate recovery including for Targeted Case Management.
- The case record must include a HCBS Comprehensive Assessment and narrative 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, escort, personal care, homemaker services, meal preparation, shopping or assisting with completion of applications and forms (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 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.

Instructions for completion of the HCBS Comprehensive Assessment

For Aging Services Case managers can be found here: Instructions for Completion of the HCBS Comprehensive Assessment 525-05-60-10 (nd.gov)

For DDPMs follow the instructions to complete the comprehensive assessment provided by the HHS DD Section

- 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 Medicaid State Plan Personal Care. 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 annually.

- DN 46, for Aging Services Case Managers.
- Individual Service Plan (ISP) for DDPMs

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 (for DD, it will be noted separately in the following chart):

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

Out-of-state care	If you are seeking to continue to authorize services for an individual while they are out of state: Include name, county of residence, funding source, description of situation for consideration, including whether medical treatment is being sought out of state.	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. *DD – requested from the Residential and Vocational Service Administrator	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 *DD – requested from the Residential and Vocational Service Administrator~~	~~Initial, every 6 months~~
Reasonable Modifications	For reasonable modification requests, include all necessary information that is indicated on the reasonable 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.	Reasonable modifications need to be re-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.

2. Person-Centered Planning (Care Plan Development)

   Aging Services Reference HCBS Case Management 525-05-30-05 (nd.gov) Policy for Person-Centered Planning Requirements.

   Medicaid State Plan Personal Care Services authorized by a DDPM should follow the guidelines provided by the Developmental Disability section on developing a person center plan of care.

~~DDPM reference (Insert policy manual link here).~~