Application for a 1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a 1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **North Dakota** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of 1915(c) of the Social Security Act.

B. **Program Title:**
Traditional IID/DD Home and Community Based Services Waiver

C. **Waiver Number:ND.0037**
Original Base Waiver Number: ND.0037.

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
04/01/16
Approved Effective Date of Waiver being Amended: 04/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Revised the maximum number of unduplicated waiver recipients who will be served during the waiver period for years three, four, and five.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☑ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	

Component of the Approved Waiver	Subsection(s)
☐ Appendix F □ Participant Rights	
☐ Appendix G □ Participant Safeguards	
☐ Appendix H	
☐ Appendix I □ Financial Accountability	
☑ Appendix J □ Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a □1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **North Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of □1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Traditional IID/DD Home and Community Based Services Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: ND.0037
Draft ID: ND.007.07.02

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/14
Approved Effective Date of Waiver being Amended: 04/01/14

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

- ○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

- ○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

The State additionally limits the waiver to individuals with intellectual disabilities with related conditions and cognitive impairment.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*

  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

- ☐ **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
North Dakota's Home and Community Based Waiver for Individuals with Intellectual Disabilities (IID) and related conditions provides an array of provider managed and participant directed services in order for individuals of all ages to have the opportunity to receive community alternatives to institutional placement. The waiver is an integral part of the North Dakota's Money Follows the Person Grant and the State's goal to reduce the number of individuals residing in the State operated ICF/IID. The State Medicaid agency, which is under the umbrella of the North Dakota Department of Human Services, is responsible to administer the waiver.

Applicants may access waiver services at the eight regional human service centers located throughout the State. The DD Program unit at each human service center is responsible for the determination of eligibility, to assist participants in accessing waiver services and monitoring of services selected by the participant. Services and supports are provided by private non and for-profit providers licensed by the Developmental Disabilities (DD) Division; and qualified service providers who are independent contractors enrolled with Medical Services within the Department of Human Services (Department). A fiscal agent assists participants and their families who wish to self-direct their services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in 1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR 441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

   1. Informed of any feasible alternatives under the waiver; and,

   2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR 440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR □441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR □441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR □431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of □1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR □433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR □431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR □431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
As required by waiver criteria a notice of intent to submit a waiver amendment is sent to all federally recognized Tribes in ND, Indian Health Services, and Tribal health programs per the North Dakota Medicaid State Plan 30 days before the waiver is submitted to CMS. In addition to the Tribal notification, a public notice and a press release is issued to seek public comment on the waiver renewal. Written public comments need to be submitted to the Department 30 days after the public notice is issued.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Krein

First Name:

Marella

Title:

DD HCBS Waiver Administrator

Agency:

Developmental Disabilities Division

Address:

1237 West Divide Avenue, Suite 1A

Address 2:

City:

Bismarck

State:

North Dakota

Zip:

58501-1208

Phone:

(701) 328-8977 **Ext:** ☐ **TTY**

Fax:

(701) 328-8969

E-mail:

mkrein@nd.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Bay

First Name:

Tina

Title:

DD Director

Agency:

Developmental Disabilities Division

Address:

1237 West Divide Avenue, Suite 1A

Address 2:

City:

Bismarck

State:

North Dakota

Zip:

58501-1208

Phone:

(701) 328-8966 **Ext:** **TTY**

Fax:

(701) 328-8969

E-mail:

tbay@nd.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Anderson

First Name:

Maggie

Title:

Executive Director of DHS

Agency:

Department of Human Services (DHS)

Address:

600 E BLVD

Address 2:

City:

Bismarck

State:

North Dakota

Zip:

58505

Phone:

(701) 328-2617 **Ext:** ☐ **TTY**

Fax:

E-mail:

manderson@nd.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

North Dakota Proposed Transition Plan for the Traditional IID/DD waiver

Assessment of Settings Process

North Dakota offers fifteen services through its Home and Community Based Services (Traditional IID/DD) 1915(c) waiver. Approximately 37 DD providers are enrolled to provide DD HCBS services. There are 29 providers enrolled to provide Residential Habilitation, 22 providers enrolled to provide Extended Services, 28 providers enrolled to provide Day Support services, and 38 providers enrolled to provide Adult Day Health services.

The majority of waiver residential services is provided in individualized settings either in the private home of a primary caregiver, or apartment, or home owned or leased by the participant and comply with the HCB settings requirements. Adult Family Foster Care is provided in a private residence owned by the licensed provider.

Ninety-Six Residential Habilitation settings, two Extended Service settings, and 38 Adult Family Foster Care settings will require changes to fully comply with the regulatory requirements because the Department will require remedial strategies and timelines for providers to come into full compliance.

One Day Support setting and four Residential Habilitation settings are presumptively non-home and community based, because they are on the grounds of or adjacent to a public institution. The Department believes they are community-based and will provide justification to show these settings do not have the characteristics of an institution and do have the qualities of home and community based settings.

There is zero Adult Day Health setting and four Day Supports settings that do not/cannot comply with Federal requirements because they are provided in institutions (e.g. hospital or skilled nursing facility) and requires a relocation plan. Currently, the Traditional IID/DD waiver does not have any individual enrolled in the Adult Day Health service.

Section 1: Results of the State's Assessment of Settings

From April through October 2014 the Department conducted a review and analysis of all settings where HCBS services are provided to eligible recipients. The Department conducted surveys of all providers of HCBS residential and non-residential services that focused on each setting's physical location, surroundings, community integration, and other environmental characteristics. The assessment was based on services, conversations with program managers, review of housing eligibility criteria, provider & consumer survey's, which included looking at the service location (i.e. consumer apartment), type (i.e. provider owned) and the building as a whole while assessing the location and other characteristics and qualities that are to be present in a HCB setting. In addition, the Department conducted a survey of recipients to assess whether the residential and non-residential settings meet home and community-based (HCB) requirements. For example, the survey asked if recipients are able to access the community as they choose, choose their schedules, freely access their money and food, decorate their residence as they choose, and choose their setting, services, and supports.

In addition, DD Program Managers provided input on each setting to validate the providers' responses. The Department conducted site visits of IID/DD waiver settings for which the State is utilizing the heightened scrutiny process.

The Department reviewed North Dakota Century Code, North Dakota Administrative Code, licensing rules and regulations and other policy materials to identify changes necessary to ensure compliance with the HCBS settings requirements.

Based on this review, the Department identified the settings that a) Fully comply; b) With changes, will fully comply; c) Presumptively do not comply but North Dakota believes to be community-based (through heightened scrutiny); or d) Do not/cannot meet HCB settings requirements.

Through this process, the Department determined the following settings that, with changes, will comply with HCBS requirements, and the remedial strategies that will be employed to bring the settings into compliance:

Adult Family Foster Care: 38 homes serving no more than 4 residents per home; the State Medicaid agency has identified the following areas where remediation is needed to comply with HCB characteristics:

•Changes are needed in regard to the experience of the residents to allow for more control of recipient schedules, access to funds, choice of meals, access to phone at any time, access to visitors day or night, curfews, and entrance doors to private areas that lock;
•Changes are needed to comply with the need for a lease or legally enforceable agreement that provides protection to address the eviction process and appeals comparable to ND landlord-tenant laws.

Remedial strategies include:

•The Department will conduct training for licensing entities, case Managers, and licensed AFFC providers on setting requirements;
•The Department will require modified AFFC house rules to be sent to the Department;
•The Department will promulgate AFFC rules to modify licensing standards to match HCB setting requirements. The State Medicaid Agency (SMA) will update policy to reflect changes in administrative rule. Once rules are finalized, the State will conduct training with licensing entities to assure understanding of new rules and licensing requirements;
•The Department will provide training and sample lease agreements that comply with ND law to AFFC providers;
•AFFC providers will secure a signed lease or other written rental agreement that includes the eviction process, which must be compliant with ND eviction law (NDCC chap. 47-32).

Assuring Compliance:

•The Department will keep a roster of attendees and dates of training to track attendance;
•The Department will review AFFC house rules submitted by AFFC providers;
•Modified rules and policy will be published on State website; and
•Require legally enforceable agreements to be sent to the Department. Agreements will be review by SMA staff, with guidance from the Legal Advisory Unit, for compliance with ND landlord/tenant law.

Ongoing Monitoring:

•Licensing entity will conduct home visits required for licensure & re-licensure. Re-licensure occurs every two years;
•Licensing visits will include HCBS setting experience interviews with all AFFC recipients.
•New rules will be incorporated into the AFFC licensing requirements and will be applied to all new and renewed licenses;
•DD Program Managers will monitor recipient experience and setting requirements at face to face quarterly visits;
•Lease agreements will be required to be submitted as part of the requirements for new and renewed AFFC licenses;
•DD Program Managers will assure that lease agreements are in place for all recipients when they initially begin using services and during annual assessments conducted in the AFFC home; and
•Providers who are unable to make necessary changes to comply with the settings requirements will be informed that they are no longer eligible to accept MA recipients. DD Program Managers will work with waiver recipients who receive services in these settings to explore options to move to a setting that does comply or to choose other services. The AFFC provider will be required to give a 30 day notice to the recipient, per landlord-tenant laws, that they will need to find alternative housing.

Final completion of all strategies: October of 2016

Extended Services: 2 settings; the Department has identified the following area where remediation is needed to comply with HCB characteristics changes are needed in regard to the experience of the recipient to allow more community interaction.

Remedial Strategies Include:

•The Department will provide Technical Assistance and training to providers to ensure more community interaction. The training will address the specific non-compliance identified at the provider location;
•The Department will conduct statewide training for providers, individuals, advocates, families/guardians, and DD Program Managers overall components of the new CMS rules;
•The Department will update licensing Administrative Code, policies, and manuals;
•The Department plans to add additional IID/DD waiver services that will incentivize providers to expand opportunities for individuals to work in integrated, competitive employment settings, by partnering with local business and providing the necessary training and support for individuals;
•If individuals are in an identified setting that doesn't meet HCB requirements or needs changes, the Department will notify the individual/guardian and, if needed, Teams will meet to work toward the compliance.

Assuring Compliance:

•The Department will keep a roster of attendees and dates of training to track attendance;
•The DD Program Managers will conduct site visits to assess compliance with community interaction during their face to face visits.

Ongoing Monitoring:

•The DD Program Managers will monitor recipient community interactions during their face to face visits;
•New rules will be incorporated into the licensing requirements and will be applied to all new and renewed licenses;
•As additional guidance for non-residential settings is provided by CMS, the Department will ensure these services and settings comply with regulations;
•Providers who are unable to make necessary changes to comply will be informed that they are no longer eligible to accept MA recipients.
•The DD Program Mangers will work with individuals who receive services in these settings to explore options to move to a setting that does comply or to choose other services.

Final completion of all strategies: December of 2016

Residential Habilitation: 96 provider-owned community residences; changes are needed to ensure that all provider-owned residential settings:

•Provide a lease or legally enforceable agreement that complies with ND landlord tenant laws (NDCC chap. 47-32);
•Have lockable bedroom doors.

Remedial Strategies Include:

•The Department will update licensing Administrative Code, policies, and manuals;
•The Department will provide sample lease agreements and information about ND's landlord-tenant laws to providers;
•Providers will submit lease policies and a sample lease template to the Department;
•Providers that do not demonstrate compliance will be required to submit a Plan of Correction to the Department; and
•The Department will conduct statewide training for providers, individuals, advocates, families/guardians, and DD Program Managers on the overall components of the new CMS rules;
•If individuals are in an identified setting that doesn't meet HCB requirements or needs changes, the Department will notify the individual/guardian and if needed, Teams will meet to work toward the compliance;
•The Department will conduct statewide training for providers, individuals, advocates, families/guardians, and DD Program Managers on the overall components of the new CMS rules.

Assuring Compliance:

•New providers will submit lease policies and a template lease as part of their License application;
•The Department will review providers' lease templates for compliance with ND landlord/tenant law;
•The Department will conduct site visits to assure changes were made (e.g., locks added to doors); and
•The Department will keep a roster of attendees and dates of training to track attendance.

Ongoing Monitoring:

•The Department will strengthen licensing renewal procedures to ensure ongoing compliance;
•The Department will update the Environmental Scan Checklist to include lockable doors;
•Providers who are unable to make necessary changes to comply will be informed that they are no longer eligible to accept MA recipients. DD Program Mangers will work with individuals who receive services in these settings to explore options to move to a setting that does comply or to choose other services. The Residential Habilitation provider will be required to give a 30-day notice to the recipient, per landlord-tenant laws, that they will need to find alternative housing.

Final completion of all strategies: December of 2016

Settings that, while presumed by CMS to be non-compliant, the Department believes are in fact community-based and provides justification for why these settings should be considered HCBS, and how the State has come to its determination. Settings that are presumably not HCBS for which the State is submitting justification to refute presumption:

Residential Habilitation: four settings with eight individuals; Located on the grounds of, or adjacent to, an Intermediate Care Facility (ICF) the State provides justification that the setting is in fact community-based:

•While these settings are located on the ground of, or adjacent to, a State ICF, individuals at these settings all have full access to the community according to their needs and preferences. The Department conducted surveys of a sample of residents in each setting, and has determined that their location does not have the effect of isolating the residents from the community. Individuals participate in community events, take trips, have hobbies, belong to local clubs, or work in the community. Resident survey results indicate that they are afforded maximum independence, control of their schedules, and access to food / visitors at any time.

•Additionally, the state completed an on-site visit (observation and visits with individuals) which validated the position that these settings do not isolate and have HCB qualities and characteristics. Individuals participate in a variety of community activities off the grounds of the State ICF, their schooling and day supports/work activities are located off the grounds of the State ICF, the homes reflect their individualized personalities, they have full access within their homes, and have visitors as they choose. These settings do not limit the individuals and have full access to the community. Visits with individuals were all positive, including indicating they were happy where they lived and individuals/guardians have made choices. A consumer voiced how he had lived elsewhere before and did not like it-enjoying where he lives now as people are nice and he can get out and do his own things.

•Staff is provided by independent DD Providers in three of the four settings. Not all residents receive housing assistance. These settings are used as a stepping stone for individuals who are unable to successfully secure housing or services off the grounds of the State ICF. The settings are either single family homes or an apartment. Some of the homes are located among homes whose occupants do not have disabilities.

•The grounds of the State ICF are no longer used solely for individuals with intellectual and developmental disabilities. Two buildings have been converted into apartment buildings, are owned by private landlords and utilized by the general public. Other businesses are also integrated throughout. There are public clinics, offices, and day care centers for children. Two additional buildings are currently being projected for community use as well. Additionally, the fitness center, which is operated by the center, is open and very well utilized by the community. There is no physical barrier surrounding buildings and grounds of the State ICF.

Assuring Compliance:

•The Department collected input from DD Program Managers and providers regarding the community-based nature of each setting and has determined that their location does not have the effect of isolating the residents from the community;
•The individuals who currently reside in these settings are assessed at least annually to determine if alternative service settings in the community are available and are afforded choice; including tours/visits to determine if they would like to move; and
•The Department will conduct site visits of each setting (observations and visits with individuals) to verify provider survey, results of DD Program Manager assessments and resident interviews.

Completion of all strategies: November of 2014

Day Supports: one day facility with 17 individuals; located on the grounds of, or adjacent to an ICF, the State provides justification that setting is in fact community-based:

•While this day facility is on the grounds of the State ICF, individuals are active in the community throughout the day with a focus on social roles and volunteering. The day program is located in a building separate from the residential settings. The grounds of the State ICF are no longer used solely for individuals with intellectual and developmental disabilities. Two buildings have been converted into apartment buildings, are utilized by the general public and owned by private landlords. Other businesses are also integrated throughout. There are public clinics, offices, and day care centers for children, two additional buildings are currently being projected for community use as well. Additionally, the fitness center, which is operated by the center, is open and very well utilized by the community.

•The Department conducted surveys of a sample of recipients regarding the experiences and environmental characteristics of the Day Facility, and has determined that recipients have frequent community interaction and are afforded maximum independence. The individuals access the community frequently throughout the day based on their preferences and needs. Community experiences include volunteering with elderly and children groups, church functions, civic organizations and boards, food pantry, local fairs and celebrations, and numerous other community events. The provider maintains close involvement with the city, and economic partners in the community.

•Additionally, the state completed an on-site visit (observation and visits with individuals) which validated the position that these settings do not isolate and have HCB qualities and characteristics. There is a focus on social roles, volunteering, meeting the needs and preferences, and consumer choice of activities. In addition to the on-site visits, some plans were reviewed and individual's choice of services was documented.

Assuring Compliance:

•The Department collected input from DD Program Managers and providers regarding the community-based nature of each setting and has determined that their location does not have the effect of isolating the residents from the community;
•The individuals who currently access this day program are assessed at least annually to determine if alternative settings in the community are available and are afforded the choice, including tours/visits to determine if they would like to receive services at another location;
•The Department will conduct site visits of each setting (observations and visits with consumers) to verify provider survey, DD Program Manager assessments and resident interviews.

Completion of all strategies: November of 2014

Settings that are not and cannot become HCB settings and the Department's plans to relocate individuals if necessary in these settings to other HCB settings. Settings that do not/cannot meet HCBS requirements:

Day Supports: four setting with five individuals; providers and DD Program Managers will be informed that services cannot be authorized for Medicaid waiver recipients in ICF settings.

Remedial Strategies for providers and clients receiving services in non-compliant settings:

•The individuals receiving day supports in these settings will be relocated to other community-based settings.
•Individuals/guardians will be provided with reasonable written notice and a choice among alternative Day Support services and providers that meet the individual's needs, preferences, and HCB setting requirements. Individuals will have the opportunity to interview and tour potential providers to make an informed decision.
•Once a new setting/provider is selected, an admission plan will be developed according to assist in a seamless transition.

Assuring Compliance:

The Department will monitor individual service plans to assure that recipients are not authorized services in non-compliant settings.

Ongoing Monitoring:

The Department will monitor individual service plans to assure that recipients are not authorized services in non-compliant settings;

Final completion of all strategies: March of 2017

Adult Day Health: zero settings with zero individuals; providers and DD Program Managers will be informed that services

cannot be authorized for Medicaid waiver recipients in a hospital or nursing facility. No waiver recipient has utilized this services since 2011.

Remedial Strategies for providers and clients receiving services in non-compliant settings:

•No remediation necessary as no waiver recipients are currently utilizing waiver services;and
•The Department will amend the Traditional IID/DD waiver to no longer include this service.

Assuring Compliance:

The Department will monitor individual service plans to assure that recipients are not authorized services in non-compliant settings.

Ongoing Monitoring:

The Department will monitor individual service plans to assure that recipients are not authorized services in non-compliant settings.

Final completion of all strategies: July of 2016

Public Input Process

The Division of Developmental Disabilities held two public stakeholder meetings in September 2014 to educate providers and stakeholders about the federal rules and the transition planning process, as well as to discuss preliminary survey results and answer questions. The transition plan was presented to stakeholders at a public meeting on October 15, 2014.

The Department provided opportunities for public comment on the proposed Amendment of the Traditional IID/DD Waiver\Transition Plan during the 30 day public comment period beginning October 22, 2014 through November 20, 2014. The proposed amendment was sent to tribal entities and other stakeholders. The entire waiver amendment document, which included the transition plan, was available for public comment online and upon request at http://www.nd.gov/dhs/services/disabilities/dd.html A public notice and a press release were issued to seek public comment on the waiver amendment. The amended waiver which included the transition plan and public notice were posted on the Department's website.

A summary of all comments received during the public comment period were added to the proposed Amendment of the Traditional IID/DD waiver\Transition Plan and submitted to CMS on November 26, 2014. The state provided a summary of public comments, including comments that agree/disagree with the State's determinations about settings that do/do not meet the HCBS requirements. A summary of the modifications made to the proposed Amendment of the Traditional IID/DD waiver\Transition Plan resulting from response to the public comment will be provided by the Department. If the Department determination differed significantly from the public comment, the information the state used to confirm its determination is included.

The state posted the proposed Amendment of the Traditional IID/DD waiver\Transition Plan with modifications made after the public comment to the Department's web site on November 26, 2014. All public comments on the provisional Amendment of the Traditional IID/DD waiver\Transition Plan will be retained and available for CMS review for the duration of the transition period or approved waiver.

Comments and public input on this proposed Amendment of the Traditional IID/DD waiver\Transition Plan were accepted in the following ways:
Email: mkrein@nd.gov
Phone: (701)-328-8977
ND Relay TTY: 800-366-6888
Mail: ND DHS Department of Human Services, Attn: Developmental Disabilities Division/Marella Krein, 1237 W. Divide Ave., Suite 1A, Bismarck, N.D. 58501

State Summary of Public Comments concerning the proposed Amendment of the Traditional IID/DD Waiver\Transition Plan

The following information contains a summary of the public comments collected in response to the proposed Amendment of the Traditional IID/DD waiver\Transition Plan and the proposed Statewide Transition Plan. The Department of Human Services (DHS) received comments from six organizations or individuals.

Based on the waiver specific and Statewide Transition Plan public comment, the Department has made changes to the Amendment of the Traditional IID/DD waiver\Transition Plan.

Public comments were received from the following individuals or organizations as they related to the proposed Traditional IID/DD Waiver:
• The Arc of North Dakota
• Protection and Advocacy Project
• AARP North Dakota
• Pathfinder Parent Center
• Designer Genes
• Parents of consumers

The following summary of public comments received by the Department includes comments in disagreement with the Department's determinations about settings that do/do not meet the HCBS requirements, comments for which the Department made updates to the Preliminary Transition Plan for the HCBS Settings under the Traditional IID/DD 1915(c) Waiver, and comments that did not result in changes to the Preliminary Transition Plan for the HCBS Settings under the Traditional IID/DD 1915(c) Waiver. Any comments that were duplicated or addressed the same topic were summarized and included in one statement.

Public Comments in Disagreement with the State's Determination

Three commenters disagree with the State's determination that the IID/DD HCB residential settings located on the grounds of or adjacent to the State ICF, do not have the effect of isolating. One commenter stated the Statewide Transition Plan indicates individuals are afforded maximum independence, control of their own schedules, and access to food/visitors at any time. Yet the Transition Plan also indicates individuals who currently reside in these settings are assessed at least annually to determine if alternative service settings in the community are appropriate. The commenter wondered why the individuals are not able to live in similar settings off of the campus.

•DHS Response: In addition to the information provided in the Statewide Transition Plan on the settings that are presumed not to be HCB, on-site visits were conducted of the settings in question which validated the Department's position that these settings are not isolating and do have HCBS qualities and characteristics. Some individuals living on the grounds of the State ICF have been unable to successfully secure housing or services off the grounds of the State ICF, which is less restrictive than living in the State ICF. Other individuals\guardians have made the choice to receive services in these settings. The individuals are assessed at least annually to determine if alternate service settings are available and are afforded the choice, including tours/visits, to determine if they would like to move. The Department will enhance this area of the Statewide Transition Plan and will also post a summary of the on-site visits that were conducted on the Department's website.

Two commenters disagree that the IID/DD day settings located on the grounds of the State ICF can be justified as community-based and should be considered as do not/cannot meet HCBS requirements. One commenter stated individuals have maximum independence, have choices to do what they want but are not able to receive similar service in the community vs. on the institution's campus and through the institution as the provider.

•DHS Response: In addition to the information provided in the Statewide Transition Plan on the setting that are presumed not to be HCB, on-site visits were conducted of the settings in question which validated the Department's position that these settings are not isolating and do have HCB qualities and characteristics. The individuals are assessed at least annually to determine if alternate service settings are available and are afforded the choice, including tours/visits, to determine if they would like to receive services at another location. The Department will enhance this area of the Statewide Transition Plan and will also post a summary of the on-site visits that were conducted on the Department's website.

Public Comments that Resulted in Changes to the Statewide Transition Plan

One commenter requested that consumer and advocacy organizations be included as key stakeholders for the remediation of IID/DD AFFC settings. One commenter feels consumers and advocacy organizations should be included in teams who

make licensure visits.

•DHS Response: DHS will add consumer and advocacy organizations to the Statewide Transition Plan list of stakeholders for Adult Family Foster Care. The Department will modify AFFC licensing rules to require the licensing entity to conduct on site interviews with AFFC recipients about their experience in the home as it relates to the setting requirements. The results of the interviews will be submitted as part of the AFFC licensing requirements and any issues will be addressed before an unrestricted license can be issued. ND Century Code dictates that the Department is responsible for licensing AFFC homes.

One commenter requested that the final transition plan regarding IID/DD AFFC settings include additional detail regarding how the plan will impact seniors and disabled populations, how the State will ensure consumers impacted by these changes will receive services in the least restrictive setting, the proposed outcomes of the activities, and the full range of stakeholders who will be involved in implementing the changes.

•DHS Response: The Statewide Transition Plan was modified to include the number of AFFC who are impacted and to include the full range of stakeholders. The Statewide Transition Plan already states if providers are unable to make necessary changes to comply they will be informed that they are no longer eligible to accept MA recipients. DDPM's will work with waiver recipients who receive services in these settings to explore options to move to a setting that does comply or to choose other services. All home and community based service options will be considered. The AFFC provider will be required to give a 30-day notice to the recipient, per landlord-tenant laws, that they will need to find alternative housing. DHS anticipates that most, if not all, providers will be willing and able to make necessary changes to fully comply with the rule.

One commenter requested that parents, guardians and individuals be notified as soon as possible regarding any changes to the IID/DD settings as a result of the transition plan and how these changes will impact their situation. Requested that someone help them craft options using a person-centered model.

•DHS Response: If individuals are in an identified setting that does not meet HCBS requirements, the Department will notify the individual/guardian and if needed, teams will meet to work toward the compliance in a person-centered manner. Clarification will be added to the transition plan to address this process.

One commenter stated for IID/DD Extended Services, the strategies seem vague and are mostly limited to training and updating rules, policies, and manuals. Additionally, another commenter stated the training proposed in the plan appears minimal, and unlikely to support the speed and degree of change needed to help day programs become more community-based. A commenter's daughter loves her job at the day center and does not want it to be "ripped away from her."

•DHS Response: For settings where changes are needed, the training will be developed once the Statewide Transition Plan has been approved by CMS and will include the overall components of the new CMS rules which includes individuals choices, consumer rights, and will address the specific noncompliance identified. For the day program settings that do not comply the Department's proposed timeline to transition individuals to new settings is March 2017. The Department will enhance this language of the Statewide Transition Plan.

One commenter expressed concern over the use of the phrase "stepping stone" used in the justification of the IID/DD residential settings that are on the grounds of or adjacent to the State ICF.

•DHS Response: The Department's intent in using the phrase "stepping stone" is for individuals who are unable to successfully secure housing or services off the grounds of the State ICF. The HCB settings on the grounds of the State ICF are less restrictive than living in the State ICF. Individuals living in these settings are assessed at least annually to determine if alternate service settings are available and are afforded the choice, including tours/visits, to determine if they would like to move. Language will be added to clarify this in the Transition Plan.

Three commenters request that consumers, family members, and other advocates be included in the IID/DD process and felt the process should be more transparent. One commenter would like to partner with DHS to train consumers, families, and guardians regarding person-centered planning.

•DHS Response: The Department used the guidance provided within the CMS tool kit to develop the process and plan. The Department also conducted two stakeholder meetings that provided information on the rules, process, preliminary results and to obtain feedback from stakeholders towards the transition plan. The purpose of the Statewide Transition Plan is to address setting compliance and does not include the person centered planning process. The Department will add language

to the Statewide Transition Plan to include consumers, advocates, and families to the training components of the rules.

Public Comments that Did Not Result in Changes to the Statewide Transition Plan

One commenter asked if information gathered from the IID/DD on-site visits will be made public to give stakeholders an opportunity to comment.

•DHS Response: The Department will post a summary of the site visits that were conducted at the settings located on the grounds of the State ICF on the Department's website to develop the Statewide Transition Plan.

One commenter questioned if DHS will have minimum standards IID/DD AFFC house rules. Commenter questioned if setting does not comply what will happen?

•DHS Response: DHS has minimum licensing standards for AFFC providers. As stated in the Statewide Transition Plan, the Department will promulgate AFFC Administrative Rules to modify licensing standards to match HCB setting requirements. Providers who are unable to make necessary changes to comply will be informed that they are no longer eligible to accept MA recipients. DDPM's will work with waiver recipients who receive services in these settings to explore options to move to a setting that does comply or to choose other services. The AFFC provider will be required to give a 30-day notice to the recipient, per landlord-tenant laws, that they will need to find alternative housing.

Two commenters requested that the State provide copies of survey results used to make the State's determinations and an explanation of the consumer survey methodologies for the IID/DD Waiver. These commenters expressed dissatisfaction with the consumer survey process. One commenter asked who helped consumers complete the survey, and inquired if the questions were easy to understand and available in alternate format.

•DHS Response: The Department provided a summary of the survey results, which included the number of consumers surveyed, questions asked, and the results of the questions. The survey results will be posted on the DHS website. The Department used the guidance provided within the CMS tool kit to develop the process and plan which included the survey questions. Staff from Human Service Centers interviewed consumers about their experiences in a face to face visit. Prior to the development of the transition plan, the Department also conducted two stakeholder meetings for consumers, advocates, and other stakeholders. The process in which these surveys were conducted was shared at the two September 2014 Public Informational meetings. The meetings provided information on the rules, process, and preliminary survey results and was another opportunity to obtain input from the stakeholders for the development of the transition plan.

One commenter recommended that there be an identified complaint process for individuals to address problems in their settings.

•DHS response: DD Program Managers conduct quarterly visits with consumers which allow opportunities for individuals to file complaints about their settings. In addition, individuals receive a rights and responsibilities brochure that addresses their right to request a fair hearing and contains contact information for the appeals supervisor.

One commenter expressed support for the future expansion of the IDD/DD Extended Services to allow for more opportunities for integrated employment and expressed concern that many clients with Down Syndrome currently move into Day Supports and are not given the opportunity to explore competitive employment.

•DHS Response: The Statewide Transition Plan identified the timeline of December 2015 to add additional employment services.

One commenter asked how IID/DD site visits for the heightened scrutiny process will be conducted, given the current large caseloads for DD Program Managers.

•DHS Response: The heightened scrutiny on-site visits process was completed by the State DD Division. The Department continues to monitor DD Program Manager caseloads and will request additional staff as necessary.

One commenter expressed concern over the consequences this transition plan may have on IID/DD services and individual choice, explaining that the plan could limit appropriate placement. Choices should in no way be limited by government-imposed restrictions. If a person decides to live happily in a place that these restrictions could deem as isolating where does our State have a place to say what is appropriate. Limited funding should not dictate where our family member chooses to live.

•DHS Response: The Department supports personal choice based on individualized strengths and interests. The Department is committed to affording waiver recipients choices within the parameters of the new rule.

One commenter shared her daughter has had eight (soon to be nine) roommates since moving into an IID/DD program at the age of 18. She has had no choice in roommates and only of the nine did she know & would have chosen for herself. The transition plan does not seem to address this issue at all.

•DHS Response: The Department is committed to affording waiver recipients choices within the parameters of the new rule.

Two commenters agreed with identified list of IID/DD settings that do not\ cannot meet HCBS requirements.

•DHS Response: Thank you for feedback on the agreement.

Three commenters commended the State for the thoughtful layout design of the transition plan document; it is easy to read and user-friendly.

•DHS Response: Thank you for the comment on the layout and design.

Two commenters appreciates the efforts on the Department to inform the public about what's happening and that the opportunity to provide comment is open.

•DHS Response: Thank you for your comment regarding the efforts on informing the public.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The North Dakota Department of Human Services acknowledges that there are legal and stakeholder partnerships with the Indian Tribes in North Dakota. These partnerships have grown throughout the years and will continue to be an integral part of implementing the revisions set forth by the American Recovery & Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA).

It is the intent of the North Dakota Department of Human Services to consult on a regular basis with the Indian Tribes established in North Dakota on matters relating to Medicaid and Children's Health Insurance Program (CHIP) eligibility and services, which are likely to have a direct impact on the Indian population. This consultation process will ensure that Tribal governments are included in the decision making process when changes in the Medicaid and CHIP programs will affect items such as cost or reductions and additions to the program. The North Dakota Department of Human Services shall engage Tribal consultation with a State Plan Amendment, waiver proposal or amendment, or demonstration project proposal when any of these items will likely have a direct impact on the North Dakota Tribes and/or their Tribal members.

Direct Impact:
Direct impact is defined as a proposed change that is expected to affect Indian Tribes, Indian Health Services (IHS) and/or Native Americans through: a decrease or increase in services; a change in provider qualifications; a change in service eligibility requirements; a change in the compliance cost for IHS or Tribal health programs; or a change in reimbursement rate or methodology.

Consultation:
When it is determined that a proposal or change would have a direct impact on North Dakota Tribes, Indian Health Services or American Indians, the North Dakota Department of Human Services will issue written correspondence via standard mail and email to Tribal Chairs, Tribal Healthcare Directors, the Executive Director of the Indian Affairs Commission, Indian Health Services Representatives and the Executive Director of the Great Plains Tribal Chairmen's Health Board. In addition to the written correspondence, the Department may use one or more of the following methods to provide notice or request input from the North Dakota Indian Tribes and IHS.
a. Indian Affairs Commission Meetings
b. Interim Tribal and State Relations Committee Meetings
c. Medicaid Medical Advisory Committee Meetings
d. Independent Tribal Council Meetings

Ongoing Correspondence:
• A web link will be located on the North Dakota Department of Human Services website specific to the North Dakota Tribes. Information contained on this link will include: notices described below, proposed and final State Plan amendments, frequently asked questions and other applicable documents.
• A specific contact at the North Dakota Department of Human Services Medical Services Division, in addition to the Medicaid Director, will be assigned for all ongoing Tribal needs. This contact information will be disseminated in the continuing correspondence with the North Dakota Tribes.
Content of the written correspondence will include:
• Purpose of the proposal/change
• Effective date of change
• Anticipated impact on Tribal population and programs
• Location, Date and Time of Face to Face Consultation OR If Consultation is by Written Correspondence, the Method for providing comments and a timeframe for responses. Responses to written correspondence are due to the Department 30 days after receipt of the written notice.

Meeting Requests:
In the event that written correspondence is not sufficient due to the extent of discussion needed by either party, The North Dakota Department of Human Services, the North Dakota Tribes, or Indian Health Services can request a face to face meeting within 30 days of the written correspondence, by written notice, to the other parties.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   (●) **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ( ) **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   (●) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Developmental Disabilities Division
   (Complete item A-2-a).

   ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight over the performance of waiver functions by other State and local/regional non-state agencies (if appropriate) and contracted entities. The North Dakota Department of Human Services is the single State Medicaid Agency which includes the DD Division and Medical Services. The DD Division, which is a division within the single Medicaid Agency, is responsible for the daily administration and supervision of the waiver, as well as issues, policies, rules and regulations related to the waiver. Oversight of waiver activities is assured through the Department's quarterly waiver coordination meetings which include representatives from Medical Services and units administering waivers.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   - (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
     Contract for Fiscal Agent services for waiver supports that are participant directed.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The ND Department of Human Services (Department), Developmental Disabilities Division (DD Division), will monitor the Fiscal Agent contract per Department contract oversight protocol.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Fiscal Agent activities will be continually monitored by families and DD Program Managers (DDPMs) through on-line individual balance sheet reports. Feedback will be solicited from staff working with the Fiscal Agent to measure satisfaction with current contractor.

The fiscal agent contract is monitored by monthly calls with DD Division Staff, monthly reports to the regional administrators and ongoing telephone contact with families and DDPMs.

The contract will be monitored at least every 6 months following the Department of Human Services contract oversight procedures.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR □431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐

Function	Medicaid Agency	Contracted Entity
Utilization management	☑	☐
Qualified provider enrollment	☑	☐
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State□s quality improvement strategy, provide information in the following fields to detail the State□s methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(A-1) Number and percent of self-directed services correctly paid by the Fiscal Agent that are authorized on the participant's authorization. N: Number of authorized services, correctly paid for by the Fiscal Agent that is on the Traditional waiver authorization self-directed supports. D: All self-directed services paid by the Fiscal Agent.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report from Fiscal Agent

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(A-2) The number and percent of transportation vendors providing self-directed services, whose qualifications are verified by the Fiscal Agent prior to delivering services. N: Number of transportation vendors providing self-directed services, whose qualifications are verified by the Fiscal Agent prior to delivering services. D: All transportation vendors providing self-directed services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report from Fiscal Agent

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State□s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DD Division staff is responsible for addressing individual problems. Problems may be corrected by providing one on one or group training /education, clarifying/rewriting policy, recouping funds that were paid in error, or termination of provider status if necessary. The state maintains documentation that tracks training, policy changes, recouped funds and terminations.

(A-1) Upon discovery, Fiscal Agent contacts DDPM for any services not on the authorization. DDPM works with family to resolve the issue. Issue and solution are documented in web based data system by DDPM. DDPM communicates resolution to Fiscal Agent.

(A-2) Upon discovery, DD Division contacts the Fiscal Agent to identify noncompliance and develop a resolution. Fiscal Agent contacts the DD Division upon resolution. If not resolved, or there's a pattern of noncompliance by the Fiscal Agent, contractual sanctions may be imposed by the DD Division.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The state additionally limits the waiver to individuals with intellectual disabilities or individuals with related conditions and cognitive impairment.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

  - ( ) **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5260
Year 2	5365
Year 3	5470
Year 4	5575

Waiver Year	Unduplicated Number of Participants
Year 5	5680

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Emergency	
Transition from Supported Employment to Extended Services	
Early Intervention	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Emergency

Purpose *(describe):*

The State reserves slots for emergency situations in which potentially eligible participants are in need of supports to ensure health and welfare.

A person is considered to have emergency needs when: The individual is at significant, imminent risk of serious harm because the primary caregiver(s)/support system is/are not able to provide the level of support necessary to meet the person's basic needs; and/or the individual requires protection from confirmed abuse, neglect, or exploitation; and whose needs can be addressed through licensed DD waiver services.

Reserved slots will be managed through the DD Division.

Describe how the amount of reserved capacity was determined:

Based on current enrollment, trend data from the State Review Team, ND Life Skills and Transition Center, ND State Hospital, and Regional DD Program Administrators.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transition from Supported Employment to Extended Services

Purpose *(describe):*

In order to assure individuals have access to the placement, training, stabilization phase of supported employment, slots are reserved. Vocational Rehabilitation will not provide supportive employment without prior assurance that funding is available for long term supported employment supports once placement, training and stabilization are complete. Some individuals may not be receiving a waiver service at the time of entrance to Supported Employment Program (SEP) and it can last up to 18 months before transition to Extended Services. The reserve capacity assures continuity of SEP services long term for individuals who are not enrolled in the waiver at initiation of SEP.

Describe how the amount of reserved capacity was determined:

The case management information system was queried to determine how many participants are currently receiving SEP through Vocational Rehabilitation and would likely transition to Extended Services during Year 1 of the waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5

Waiver Year	Capacity Reserved
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Early Intervention

Purpose *(describe):*

The State will reserve slots for children birth to three years of age to provide intervention in a timely manner for young children who will benefit from early intervention services. The primary caregiver chooses which option best meets their family's needs. If they choose waiver funded services, reserved slots will be assigned based on eligibility date once general waiver slots have been reached.

Describe how the amount of reserved capacity was determined:

Based on current waiver enrollment and trend data.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	135
Year 2	135
Year 3	135
Year 4	135
Year 5	135

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Until the waiver cap is reached, minus the reserved slots, the eligible participants will be enrolled on a first-come, first-serve basis. When the cap is reached, a waiting list based on time of application will be used. If the reserved capacity for 'Emergency' has been exhausted, applicants whose situation meets the definition for 'Emergency' will be given priority on the waiting list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ○ **SSI Criteria State**
   - ◉ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR 435.217)

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

- [x] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Individuals eligible under sections 1902(a)(10)(A)(i)(I),(IV),(VI),and (VII); section 1902(a)(10)(C)(ii)(I); section 1902 (a)(52)of the SSA; 42 CFR 435.308 and .310; and all other optional eligibility groups covered under the ND State Plan.

Special home and community-based waiver group under 42 CFR □435.217) *Note: When the special home and community-based waiver group under 42 CFR □435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR □435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR □435.217.**

Select one and complete Appendix B-5.

- (•) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR □441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR □435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR □435.217 group.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR □435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. **Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. **Regular Post-Eligibility Treatment of Income: 209(B) State.**

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in □1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR §435.121**

    Specify:

    [ ]

  - ( ) **Optional State supplement standard**
  - (●) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify percentage: [ ]

    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]

  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]

  - ( ) **Other standard included under the State Plan**

    Specify:

    [ ]

- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]

- ( ) **Other**

  Specify:

  [ ]

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

Specify the amount of the allowance (*select one*):

- ( ) **The following standard under 42 CFR §435.121**

  Specify:

- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- (●) **The following dollar amount:**

  Specify dollar amount: 655 The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR □435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

  Specify:

- ( ) **Other**
  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 □CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ◉ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR □435.726 or 42 CFR □435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR □435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR □441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

   ii. **Frequency of services.** The State requires (select one):

   - ○ **The provision of waiver services at least monthly**
   - ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

   If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

   Minimum frequency: Quarterly

   Individuals are screened to the ICF/IID level of care when it is expected that the person will need and receive a waiver service within 30 days and that waiver services will be furnished at least quarterly. It is expected that non intermittent services will be delivered monthly.

   when a partipant is only receiving an intermittent service, such as Environmental Modification or Transportation, the service may not be delivered during a particular month. The DDPM will monitor the use of services as part of the quarterly enhancement review (QER). If, based on the QER, the participant has not received a monthly service, the DDPM will initiate a monthly contact with the participant and\or legal decision maker to ensure health and safety, to determine if the service continues to be appropriate, and whether there continues to be a reasonable expectation that the service will be delivered monthly. If the participant is found not to be utilizing waiver services, a re-evaluation of level of care will be conducted to reassess the need for waiver services.

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

   - ◉ **Directly by the Medicaid agency**
   - ○ **By the operating agency specified in Appendix A**
   - ○ **By an entity under contract with the Medicaid agency.**

   Specify the entity:

○ **Other**
Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

DDPMs at the Regional Human Service Centers will perform the initial evaluation of level of care for waiver applicants. The minimum qualifications for DDPMs require that they meet the criteria for Qualified Developmental Disabilities Professional (QDDP). This criteria is as follows:
Definition: Individual who:
483.430(a)(1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and
(a)(2) Is one of the following:
(a)(2)(i) A doctor of medicine osteopathy
(a)(2)(ii) A registered nurse
(a)(2)(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) and who are licensed, certified, or registered as applicable, to provide professional services by the State in which he or she practices. Professional staff who do not fall under the jurisdiction of State licensure, certification or registration requirements must meet the following:
2 - 483.430(b)(5)(i) To be designated as an Occupational therapist must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
483.430 (b)(5)(iii) To be designated as a Physical therapist must be eligible For certification as a physical therapist by the American Physical Therapy Association or another comparable body.
483.430(b)(5)(v) To be designated as a psychologist must have at least a Master's degree in psychology from an accredited school.
483.430(b)(5)(vi) To be designated as a social worker , an individual must (A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or
(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
483.430(b) (5) (vii) To be designated as a speech-language pathologist or audiologist, an individual must
(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or
(B) Meet the educational requirements for certification and be in the process or accumulating the supervised experience required for certification.
483.430(b)(5)(viii) To be designated as a professional recreation staff member an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
483.430(b)(5)(ix) To be designated as a professional dietician, an individual must be eligible for registration by the American Dietetic Association.
483.430(b)(5)(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human service field (including but not limited to: sociology, special education, rehabilitation counseling, and psychology).
"Human services field" includes all the professional disciplines stipulated in 483.430(a)(3)(i)(ii) and 483.430(b)(5)(i)-(ix) as well as any related academic disciplines associated with the study of: Human behavior (e.g., psychology, sociology, speech communication, gerontology etc.), human skill development (e.g., education, counseling, human development, humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g. rehabilitation counseling), or the human condition (e.g., literature, the arts).
3 - An individual with a "Bachelor's degree in a human service field" means an individual who has received: at least a bachelor 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 services field, as defined above.
Other A. Individuals who have a bachelor's degree; and
B. Developmental Disabilities module certification; and
C. One year experience working with individuals with developmental disabilities.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of

care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Individuals that may be eligible for ICF/IID level of care include individuals with a diagnosis of intellectual developmental disabilities as defined in ND Administrative Code 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009 with accompanying cognitive limitations, and who are eligible for Medicaid. An evaluation instrument is used in North Dakota to determine whether an individual meets the minimum criteria for ICF/IID level of care. The evaluation instrument is a component of an automated system and is used to assess individual strengths and needs and to assist in the determination of eligibility as well as evaluation of level of care. The individual assessment describes the most current DSM diagnoses and the level of supports needed by an individual in the following areas: residential, day services, motor skills, independent living, social, cognitive, communication, adaptive skills, behavior, medical and legal. Once the evaluation is completed, an indicator is electronically derived from the scores that determine whether an individual meets the basic criteria for the ICF/IID level of care, if all other criteria are met. The HCBS indicator, in conjunction with the professional judgment of the DDPM, will serve as the basis as to whether the individual will be screened for waiver services.

If the HCBS indicator is "N" (no), the individual cannot be screened to the ICF/IID Level of Care. If the HCBS indicator is "Y" (yes), the individual may be screened, provided all other criteria are met. If the HCBS indicator is "P" (professional judgment), the DDPM applies professional judgment, utilizing the guidelines for ICF/IID Level of Care Screenings to determine if the individual can be screened.

e. **Level of Care Instrument(s).** Per 42 CFR 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The DDPM will obtain psychological, medical, educational and other relevant assessments and information as part of the application and intake process to the Regional Human Service Center. The DDPM will schedule an interview/visit with the individual and/or legal decision maker, to assess the individual's needs and desired outcomes. During the initial visit(s), the DDPM will complete the evaluation instrument. The evaluation results are entered into the web based data system to determine if the minimum criteria are met for level of care. If the finding is affirmative, the DDPM will complete the Case Action Form to document the level of care for the MMIS payment system. If it is determined the individual does not meet the level of care, the individual and/or legal decision maker will be notified of their right to appeal the adverse decision. The level of care criteria used for the re-evaluation is the same criteria applied for the initial level of care. The DDPM will complete the Progress Assessment Review (PAR) based on the most current assessment information available and an interview with the individual and/or those who know the person best. The re-evaluation does not require an updated psychological assessment if the diagnosis has been confirmed, unless it is determined that a new assessment will be beneficial or is needed. The results are entered into the web based data system to determine if the minimum criteria are met for level of care and continued enrollment in waiver services. If the finding is affirmative and all other criteria are met, the DDPM will complete the Case Action Form to document the level of care for the MMIS payment system. If it is determined the individual does not meet the level of care, the individual and/or legal decision maker will be notified of their right to appeal the adverse decision.

g. **Reevaluation Schedule.** Per 42 CFR 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**

○ **Other schedule**
Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

When the evaluation results are completed and activated, a system generated alert due date is calculated to plus one year minus one day to ensure that the re-evaluation of level of care is performed on a timely basis. In addition, when the Case Action Form is completed and activated, a system generated alert is created with an alert due date equal to the active case action termination date or end date, minus two months to ensure that the re-evaluation of level of care is performed on a timely basis and entered into MMIS. The DDPM and their supervisors have the ability to review all alerts by manager assigned caseload, due date, type of alert, individual case.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Documentation of the Level of Care Evaluations/Reevaluations is maintained electronically for each individual for a minimum of 3 years+ in the web based data system application which can be accessed at the Regional Human Service Center or DD Division. The MMIS system also maintains a record/history of level of care determinations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State□s quality improvement strategy, provide information in the following fields to detail the State□s methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(B-1) Number and percent of new waiver enrollees who had an initial LOC indicating need for ICF/IID LOC prior to receipt of services. N: Number of new waiver enrollees who had a LOC prior to receiving services. D: All new waiver enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Query from web based data system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(B-2) Number and percent of waiver participants who have an accurately completed initial level of care determination. N: Waiver participants who have an accurately completed initial level of care determination. D: Sample of waiver participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Queries from web based data system - Manual Level of Care Integrity Review

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The DD Division reviews patterns and trends of inaccurate PARs/LOC determinations that result in a licensing deficiency and require a corrective action plan. The DD Division follows up, to ensure the corrective action plan is completed (addressed in B-2 below).

Patterns of errors will be analyzed to determine if they are the result of individual, region, or systemic issues. The Regional DD Program Administrators (DDPAs) will address individual issues and Regional training needs. The DD Division is available to assist Regional DD Program Administrators, as well as addressing systemic issues.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State□s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
It is the responsibility of the DDPM to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance.

(B-1) When the DD Division is notified that a LOC is not completed either through quarterly case reviews or through denied or suspended claims, the DD Division will contact the DDPA for information or correction. The DDPA contacts the DDPM for information and to complete the LOC. The DD Division is then notified upon completion of the corrective action plan.

(B-2) From the integrity review, a list of inaccuracies is provided to each Human Service Center. Patterns and trends of inaccurate PARs/LOC determinations can result in a licensing deficiency and require a corrective action plan. The DD Division follows up, to ensure the corrective action plan is completed timely.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR □441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals eligible for the waiver will be provided with a choice of institutional or HCBS services, feasible alternatives under available waivers will be explained by the DDPM and a description of services and list of all available DD Licensed Providers will be provided to the individual and/or legal representative. The individual choice will be documented on the Individual Service Plan (ISP). This information will be provided at the time of waiver eligibility determination and annually thereafter.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed ISP is maintained in the participant's file at the Regional Human Service Center for more than three years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The services of an interpreter will be arranged when a participant and/or their legally responsible caregiver is unable to independently communicate with the DD Division staff, DDPM/DDPA, or the fiscal agent. Written material may also be modified for non-English speaking participants. The North Dakota Department of Human Services has a Limited English Proficiency Implementation Plan to assist staff in communicating with all participants.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Day Supports		
Statutory Service	Extended Services		
Statutory Service	Homemaker		
Statutory Service	Residential Habilitation		
Extended State Plan Service	Extended Home Health Care		

Service Type	Service		
Other Service	Adult Family Foster Care		
Other Service	Behavioral Consultation		
Other Service	Environmental Modifications		
Other Service	Equipment and Supplies		
Other Service	Family Care Option		
Other Service	In-Home Supports		
Other Service	Infant Development		
Other Service	Parenting Support		
Other Service	Transportation Costs for Financially Responsible Caregiver		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Adult Day Health\Adult Day Care is a community-based service offered within a group setting designed to meet the needs of functionally impaired individuals. It is a structured, comprehensive service that provides a variety of social and related support services in a protective setting during part of a day. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Day Health\Adult Day Care service requires that a minimum of three hours per day through a maximum of 10 hours per day, on a regularly scheduled basis, for one or more days per week.

Non-medical transportation may be included as a part of this service and is included in the rate if the provider offers it.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency
Provider Type:
Adult Day Care provider
Provider Qualifications
License *(specify):*
Agency only - N.D.C.C. 23-16; N.D.A.C. 33-07-01; 33-07-03.1; N.D.A.C. 33-03-24.1-10
Certificate *(specify):*

Other Standard *(specify):*
Agency Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07
Verification of Provider Qualifications
Entity Responsible for Verification:
ND Medical Services Division
Frequency of Verification:
Initial/Re-enrollment every two years, and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Day Supports provide assistance to the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Day Supports are generally furnished in a non-residential setting, separate from the home or facility where the participant resides, but may be furnished in the individual's home during traditional Day Supports schedules if the individual(s)' needs preclude traveling from the home on a regular basis. Day Supports focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech therapies listed in the participant's plan. Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the participant's plan and the service originates from the licensed day program.

Rates for Day Supports may include transportation costs to access program related activities in the community. Transportation does not include travel between the individual's home and the Day Supports program site. Any transportation provided to an individual as a part of the rate is not billable as a discrete service and cannot duplicate transportation provided under any other service in this waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An individual may be enrolled concurrently in Day Supports, Extended Services and Adult Day Health, per DD Division policy. However, Adult Day Health, Day Supports, and hours of employment in Extended Services combined cannot exceed 40 hours per week. Billing for services may not be duplicated for a time period (i.e. billed for both 1 to 5 p.m. on April 1.)

Provider managed Day Support may not be billed at the same time as Extended Services, State Plan Personal Care Services, In-Home Supports, Family Care Option, Family Care Option III, Residential Habilitation, Adult Day Health, or Homemaker services.

This service will not be authorized, nor payment made, for individuals who are eligible for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition.

This service may not duplicate services provided under Extended Services, Adult Day Health, or Residential Habilitation.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed DD Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:
Agency

Provider Type:
Licensed DD Provider

Provider Qualifications

License *(specify)*:
Licensed to provide Day Habilitation according to NDAC 75-04-01.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Extended Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Extended Services is ongoing support for an individual in supported employment upon completion of training and stabilization in employment; providing on or off the job employment-related support for individuals needing intervention to assist them in maintaining employment. This may include job development, replacement

in the event of job loss, and, for provider managed services, must include a minimum of two onsite job skills training contacts per month and other support services as needed to maintain employment. It may also include providing other support services at or away from the worksite. If offsite monitoring is appropriate, it must, at a minimum, consist of two meetings with the individual and one contact with the employer each month.

Transportation costs for individuals from their residence to their workplace may be included in the service rate when an individual needs it as a support intervention necessary for the individual to maintain employment. It is not allowed as a substitute for personal, public or generic transportation, is not billable as a discrete service, and cannot duplicate any transportation through the State Plan or waiver transportation service. If transportation is to be included in the rate, the Regional DDPA must certify the number of individuals for whom transportation is necessary as part of intervention to successfully support continued employment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An individual may be enrolled concurrently in Day Supports, Extended Services and Adult Day Health, per Division policy. However, Adult Day Health, Day Supports, and hours of employment in Extended Services combined cannot exceed 40 hours per week. Billing for services may not be duplicated for a time period (i.e. billed for both 1 to 5 p.m. on April 1.)

Provider managed Extended Services may not be billed at the same time as Day Supports, State Plan Personal Care Services, In-Home Supports, Family Care Option, Family Care Option III, Residential Habilitation, Adult Day Health, or Homemaker services.

Extended Services is not provided in a sheltered work shop setting.

Supported employment/ Extended Services does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.

This service is limited to individuals who have exhausted eligibility for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an inter-departmental plan of transition.

For participant-directed services, transportation is not included as part of this support. In addition, intervention will be determined according to the Extended Services Operation Manual.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Extended Services Provider
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Extended Services

Provider Category:

Agency

Provider Type:
Licensed Extended Services Provider
Provider Qualifications
License *(specify):*
Developmental Disabilities service provider licensed to provide Extended Services per ND Administrative Code 75-04-01.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annual license renewal

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Extended Services

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
For self-directed service delivery the individual provider must be 18 years or older.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Agent
Frequency of Verification:
Prior to hiring

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
The purpose of homemaker services is to complete environmental tasks that an individual with a disability is not able to complete in order to maintain that individual's home such as housework, meal preparation, laundry, shopping, communication, and managing money. Homemaker service is offered to participants living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks. If the participant lives with a capable person or provider, prior approval from the State office is required.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
If shopping is the only identified task for homemaker services, homemaker services should not be authorized. Transportation or escorting the client is not an allowable task under Homemaker services.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. This amount allows for approximately 12 hours of service per month at the highest provider rate allowed. This cap may be increased as determined by legislative action. The DDPM informs a participant of the service cap.

Note: The service rate is capped by legislative appropriation. The cap is different for agency providers than individual providers as agency providers are allowed an administrative reimbursement. Providers may choose to use a rate that is less than the cap.

Homemaker services cannot be provided to an individual living with a legally responsible caregiver (such as a parent or spouse). Homemaker services cannot be provided along with Residential Habilitation or Adult Family Foster Care.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Service Provider
Individual	Qualified Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Qualified Service Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Agency Enrolled QSP per N.D.A.C. 75-03-23-07
Verification of Provider Qualifications
Entity Responsible for Verification:
ND Medical Services Division
Frequency of Verification:
Initial/Re-enrollment every two years and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual
Provider Type:

Qualified Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a QSP according to NDAC 75-03-23-07 and demonstrates competencies in homemaker standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years and/or upon notification of provider status change.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Residential Habilitation consists of an integrated array of individually designed training activities, assistance and supervision. Residential Habilitation is provided in licensed/unlicensed community residential settings that include group homes and homes leased, owned or controlled by individuals.

Residential Habilitation includes:

(l) Habilitation Services aimed at assisting the participant to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the participant to improve his/her ability to reside as independently as possible in the community.

(2) Assistance in activities of daily living when the participant is dependent on others to ensure health and safety.

(3) Assistance, support, supervision and monitoring that allow the individual to participate in home life or community activities.

(4) Residential Habilitation may include professional services not available as a state plan service, as needed to meet health and welfare needs of participants. This may include behavior management, nursing, or dietetics. Behavior management services do not duplicate state plan services, as services include ongoing development, application, and monitoring of behavior management plans for individuals and training of direct service staff. Nutritional services or dietary services that exceed the State Medicaid Plan may be provided. Staff employed or contracted by provider agencies must meet licensure or certification appropriate to their scope of practice according to North Dakota Century Code Title 43. Professional services included as part of a rate are not billable as a discrete service.

Residential Habilitation is provided in the following settings:

"Congregate Care" means a specialized program to serve participants with developmental disabilities whose health and medical conditions are stable and do not require continued nursing and medical care, and are served within a community group-living arrangement.

"Minimally Supervised Living Arrangements (MSLA)" means either:
a. A group home with an available client adviser; or
b. A community complex that provides self-contained rented units with an available client adviser.

"Transitional Community Living Facility (TCLF)" means a residence for participants with individualized programs consisting of social, community integration, and daily living skills development preliminary to entry into less restrictive settings.

"Supported Living Arrangement (SLA)" means a program providing a variety of types of living arrangements that enable participants with disabilities to have choice and options comparable to those available to the general population. Participants entering this service shall have the effects of any skill deficits subject to mitigation by the provision of individualized training and follow-along services.

"Individualized Supported Living Arrangements (ISLA)" means a residential support services option in which

services are contracted for a participant based on individualized needs resulting in an individualized rate setting process and are provided to a participant in a residence rented or owned by the participant.

"Family Care Option III (FCO III)" is an individual support provided in a setting for adolescents or young adults who are unable to live in a family home setting. In exceptional circumstances this service may support younger children in order to maintain them in their home community. This service also focuses on close communication and coordination with families and the school system during the transition period.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Participants who receive Residential Habilitation may not receive In-Home Supports, Family Care Option, Parenting Support, State Plan Personal Care Services, Adult Family Foster Care, Behavior Consultation, or Homemaker Services.

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

This service is not available at the same time of day as Day Supports, Extended Services or one of the State Plan Medicaid services that works directly with the person.

Residential Habilitation rates do not include client transportation.

Services not available in ISLA's include services provided to a participant by a family member or in a home of a family member. A family member means relatives to the second degree of kinship (parents, grandparents, siblings).

SLA services are limited to 8 hours per month.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Provider Qualifications

License *(specify):*

Licensed according to NDAC 75-04-01.

Certificate *(specify):*

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annual license renewals

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Extended Home Health Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Extended Home Health Care is an Extended State Plan Service which is available when an eligible participant has maximized the amount of service available under the Medicaid State Plan. The participant's plan must address health and safety issues and support Home Health Care as a service necessary in order for the eligible participant to remain in a family (natural or adoptive) setting in their community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is not available to participants receiving Residential Habilitation.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended Home Health Care

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
Certified as a Home Health Care provider under Medicare or a DD Licensed Provider of In-Home Supports, Family Care Option, Family Care Option III Services
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency and DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Family Foster Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Assistance is provided to a participant for ADL's, IADL's and supportive services provided in a licensed private home by an Adult Family Foster Care provider that lives in the home. Adult Family Foster Care (AFFC) is provided to adults who receive these services while residing in a licensed AFFC home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service must be provided in a licensed AFFC home. Services are provided to the extent permitted under state law.

AFFC may not be provided in conjunction with Residential Habilitation, In-Home Supports, Family Care Option, Homemaker Services, Parenting Support, Transportation costs the Financially Responsible Caregiver, Equipment and Supplies, Environmental Modifications or with Medicaid State Plan Personal Care services. Non-medical transportation is a component of AFFC and is included in the rate. Room and board

costs are not included in the AFFC payment.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. AFFC rates were established to be comparable with the rates that providers charged their private pay clients for the same service. If the participant's needs cannot be met within the allowed rate, the DDPM explores other waiver service options with the participant, including nursing home placement. The DDPM makes participants aware of the service cap.

The total number of individuals who live in the AFFC home who are unrelated to the AFFC provider cannot exceed four.

Limits may be increased as determined by legislative action.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed AFFC provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Family Foster Care

Provider Category:
Individual

Provider Type:
Licensed AFFC provider

Provider Qualifications

License *(specify)*:
Licensed according to NDCC 50-11, NDAC 75-03-21

Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled as a Qualified Service Provider according to NDAC 75-03-23-07.

Verification of Provider Qualifications

Entity Responsible for Verification:
State Medicaid Agency, Aging Services and Medical Services Divisions.

Frequency of Verification:
Initial licensing of an AFFC home is valid for 1 year. AFFC homes are re-licensed every 2 years after the 1-year initial licensing period.

Re-enrollment of QSP status is required every two years or upon expiration of Qualified Service Provider status whichever comes first, and/or upon notification of provider status change

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR □440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Consultation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Funds for this service may be accessed to meet the excess disability related expenses associated with maintaining a participant in their primary caregiver's home and not covered through the Medicaid State Plan. Behavioral Consultation Services provide expertise, training and technical assistance to assist primary caregivers, and other natural supports, to develop an intervention plan designed to address target behaviors. Allowable activities covered are:

(1) Observing the participant to determine needs;

(2) Assessing any current interventions for effectiveness;

(3) Developing a written intervention plan;

(4) Clearly delineating the interventions, activities and expected outcomes to be carried out by family members and natural supports in the intervention plan;

(5)Training of the primary caregiver to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies;
(6)Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes;
(7)Training and technical assistance to primary care giver(s) to instruct them on the implementation of the participant's intervention plan; and/or
(8) Participating in team meetings.

The behavior support plan is determined and written by the participant's team.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limitations are for the development and the evaluation of the plan and training of the primary caregiver. Behavioral Consultation does not include implementation of the plan by the behavior consultants and training of staff.

Behavioral Consultation excludes services provided through the IEP.

Behavioral Consultation is limited to $5200 per participant per State Fiscal Year per participant unless an exception is approved by the DHS/DDD to prevent imminent institutionalization.

To avoid duplication of services, behavioral consultation is not available to individuals who receive Residential Habilitation as behavioral consultation is included as a professional service in the Residential Habilitation service.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Consultation

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify)*:
A currently licensed ND Behavior Analyst, ND Registered Behavioral Analyst, ND Psychiatrist or Psychologist
Certificate *(specify)*:
A currently certified ND Behavior Modifications Specialists or QDDP through a licensed DD Provider within the participant's plan of care
Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
State Medicaid Agency, DD Division, DDPM

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Modifications

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Funds for this service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a participant living in their own home or in the home of their primary caregiver. This home must be owned by the participant or the participant's primary caregiver.

Environmental Modifications consists of modifications made to a participant's home or vehicle. Home Modifications are age appropriate physical modifications required by the individual's plan of care developed by the participant's team, which are necessary to ensure the health, welfare, and safety of the participant or/and enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the participant.

An environmental modification provided to a participant must:
(a) relate specifically to and be primarily for the participant's disability;
(b) have utility primarily for a person who has a disability;
(c) not be an item or modification that a family would normally be expected to provide for a non-disabled family member;
(d) not be in the form of room and board or general maintenance.

This service covers purchases, installation, and as necessary, the repair of the following home modifications which are not covered under the Medicaid State Plan:
(1) Ramps and Portable Ramps
(2) Lifts, elevators, manual, or other electronic lifts,
(3) Modifications and/or additions to bathroom facilities
a) Roll in shower
b) Sink modifications
c) Bathtub modifications
d) Toilet modifications
e) Water faucet controls
(4) Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
(5) Specialized accessibility/safety adaptations/additions
a) Electrical wiring
b) Fire/safety adaptations, including alarms
c) Shatterproof windows
d) Floor coverings for ease of ambulation only
e) Modifications to meet egress regulations if there are no other egress options available in the structure
f) Automatic door openers/doorbells
g) Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant.

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community and are required by the participant's plan of care. The installations of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle or lease itself. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Covered Vehicle Modifications are:
(1) Door modifications
(2) Installation of raised roof or related alterations to existing raised roof system to increase head clearance
(3) Lifting devices
(4) Devices for securing wheelchairs or scooters
(5) Handrails and grab bars
(6) Seating modifications

(7) Lowering of the floor of the vehicle
(8) Safety/security modification
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of service for environmental and vehicle modifications will not exceed $20,000 per participant for the duration of the waiver. The authorization database will track the amount authorized and utilized to prevent over-expenditure.

Items that are not of direct or remedial benefit to the participant are excluded from this service.

Repair of items purchased through the waiver or purchased prior to waiver participation is covered, as long as the item is identified within this service definition, determined by the team and appropriate professional to be necessary, and the cost of the repair does not exceed the cost of purchasing a replacement piece of the item.

Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Environmental Modifications:
The base product and one repair of the home modification which is cost efficient and appropriately meets the needs of the participant will be covered.

Environmental modifications will be limited to remodels of an existing structure (home the participant is living in). Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Any purchases over $500 require three estimates to determine the most cost effective material for the adaptation to meet the participants need.

Environmental modifications will not be approved for new construction (building a new house).

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as roof repair, general plumbing, swimming pools, central air conditioning, service & maintenance contracts and extended warranties, etc.

Home modifications purchased for exclusive use at the home school are not covered. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained. All services shall be provided in accordance with applicable State or local building codes.

Vehicle Modifications:

The cost of renting/leasing a vehicle with adaptations, service and maintenance contracts and extended warranties, and adaptations purchased for exclusive use at the school/home school are not covered.

The base product and one repair of the vehicle modification which is cost efficient and appropriately meets the needs of the participant will be covered.

Payment may not be made to adapt the vehicle that are owned or lease by paid providers of waiver services.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
None
Certificate *(specify):*
None
Other Standard *(specify):*
The participant and/or legal decision maker along with team members will identify the appropriate environmental modifications within the participant's plan. In addition to identifying the appropriate environmental modifications, the Team determines if the adaptations can be made by family members, i.e. a father building a ramp according to ADA specifications. In those specific circumstances, the participant and/or legal decision maker obtains the specified material from an individual who is enrolled as a vendor with the Fiscal Agent.

The Team will consider the technical and safety requirements of specific environmental modifications when they consider recommending individual vs. agency provider specifications, i.e. installation of a van lift would only be authorized through a vendor authorized by the manufacturer.

Participants and/or legal decision maker along with team members will identify the appropriate Environmental Modifications within the participant's plan. The participant and/or legal decision maker will obtain the material from a vendor who is enrolled with the Fiscal Agent.

As applicable: building permits, Bonded and Licensed to practice profession, enrolled with ND Secretary of State, and in good standing with Workforce Safety. American's with Disabilities Act guidelines will be followed.

The vendor must provide the item approved in participant's plan, or recommended by a licensed professional and selected by individual or legal decision maker as cost effective.
Verification of Provider Qualifications
Entity Responsible for Verification:
DDPM
Frequency of Verification:
Prior to modifications

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Agency
Provider Qualifications
License *(specify):*
NDCC 43-07, NDCC 43-09, NDCC 43-18
Certificate *(specify):*
None
Other Standard *(specify):*
The participant and/or legal decision maker along with team members will identify the appropriate environmental modifications within the participant's plan. The participant and/or legal decision maker obtains the material and finds an appropriate professional who is or will be enrolled with the Fiscal Agent.

As applicable: building permits, Bonded and Licensed to practice profession, enrolled with ND Secretary of State, and in good standing with Workforce Safety. American's with Disabilities Act guidelines will be followed.

The participant and/or legal decision maker must select a vendor who will provide the item approved in the participants plan, or recommended by an appropriate professional and selected by the participant or legal decision maker as cost effective.
Verification of Provider Qualifications
Entity Responsible for Verification:
DDPM
Frequency of Verification:
Prior to Modifications

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR □440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Equipment and Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Funds for this service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a participant in their home. Equipment and Supplies enable a participant to remain in and be supported in their home, preventing or delaying unwanted out of home placement or imminent institutionalization. Individual needs identified through the person centered planning process in the following areas can be addressed through the individual budget process.

This service covers purchases of the following which are not covered under the Medicaid State Plan:
(a) devices, controls, or appliances, specified in the participant's plan, that enable participants to increase their ability to perform activities of daily living (i.e. grab bars, portable lifts or lift systems);

(b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;

(c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

(d) Assistive technology device means an application or software item, or piece of equipment, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.

Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:
1) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
4) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
5) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
6) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants; and

(e) Personal Emergency Response System is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep and maintenance of devices/systems are provided.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All equipment and supplies shall meet applicable standards of manufacture, design and installation.

Equipment and Supplies is limited to $20,000 per participant for the duration of waiver. The authorization database tracks the amount authorized and utilized to prevent over expenditure.

Experimental or prohibited treatments are excluded. These include treatments not generally accepted by the medical community as effective and proven, not recognized by professional medical organizations as conforming to accepted medical practice, not approved by FDA or other requisite government body, are in clinical trials or further study or are rarely used, novel, or unknown and lack authoritative evidence of safety and efficacy.

A written recommendation must be obtained by an appropriate professional (OT, PT, SLP, etc.) and three separate trials of equipment, when appropriate, to ensure that the equipment will meet the needs of the participant prior to consideration for approval.

Generic technical devices (tablets, computers, etc.) are not allowed.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Equipment and Supplies

Provider Category:
Agency
Provider Type:
Vendor
Provider Qualifications
License *(specify)*:
None
Certificate *(specify)*:
None
Other Standard *(specify)*:
Participant and/or legal decision maker along with the team members will identify the appropriate equipment and supplies within the participants plan. The participant and/or legal decision maker will obtain the equipment and supplies from a provider who is enrolled with the ND Secretary of State and with the Fiscal Agent. The vendor must provide the item approved in the participant's plan.
Verification of Provider Qualifications
Entity Responsible for Verification:
DDPM
Frequency of Verification:

Quarterly or as needed

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Care Option

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Family Care Option will be provided out of the child's home, in another family home meeting the licensing standards for Family or Adult Family Foster Care on a part-time or full-time basis. Family Care Option may be appropriate for eligible waiver participants less than 21 years of age who cannot remain in their natural family home on a full-time basis.

This service focuses on close communication and coordination with families and the school system during the

transition period. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes and avocation; and aid involvement in family routines and participation in community experiences and activities.

Family Care Option is available if the eligible waiver participant is receiving the proper parental care and education necessary for the participant's physical, mental or emotional health as referenced in North Dakota Century Code 27-20-02 and is not considered boarding care according to the definition of the North Dakota Department of Public instruction. Participants receiving services in Family Care Option must have an active IEP (Individual Education Plan).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Family Care Option is not available in group residential settings.

Family Care Option is not available when the participant receives Family Care Option III, or Adult Family Foster Care or Residential Habilitation service.

IHS is not available in the Family Care Option setting.

This service is not available to children in foster care under the custody of county social services.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Care Option

Provider Category:
Agency

Provider Type:
Agency

Provider Qualifications

License *(specify)*:
Licensed according to NDAC 75-04-01.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
In-Home Supports

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
This service may be accessed to meet the excess care needs related to the participant's disability associated with maintaining a participant in their home and not covered through the Medicaid State Plan. In-Home Supports (IHS) is intended to support the participant and to permit the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement.

In-Home Supports benefits the primary caregiver by assisting the participant in activities of daily living such as eating, drinking, toileting, and physical functioning; improving and maintaining mobility and physical functioning when these tasks require more than one person to accomplish. It may also include assisting the participant with maintaining health and personal safety while the primary caregiver is home and attending to other household tasks and children and no other natural support is available.

In-Home Support can be provided to the participant while the primary caretaker is either away from the home or is home, but unavailable to care for the individual. The team determines the appropriate tasks or activities that are provided during the parent's present or absence and this is included in the participants plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Hours of support will be limited to 300 per month per participant unless an exception is approved by the DD Division as preventing imminent institutionalization.

Individuals providing IHS may not live in the same home as the participant.

IHS is not authorized when Part B services of IDEA offered through the North Dakota Department of Public Instruction are available to the participant.

IHS cannot be provided for the purposes of administering a specialized curriculum or service that is not specifically identified on the participant's service plan (ISP section of the plan).

IHS is not authorized when Day Support or Extended services are available to the participant.

An IHS participant cannot be authorized to receive both provider managed and self-directed at the same time.

For families who have more than one participant in the household receiving this service, each participant's individual needs are evaluated by the Team to determine the total number of hours and staff needed to ensure each participants health and safety.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid.

To avoid duplication, IHS cannot be provided to participants receiving Residential Habilitation, State Plan Personal Care, or Family Care Option services.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-Home Supports

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
Licensed according to NDAC 75-04-01.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-Home Supports

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As required by the participants plan. For self-directed service delivery the individual provider must be 18 years or older.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Agent
Frequency of Verification:
Prior to hiring for verification of age 18

Annually review of the participants plan

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Infant Development

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Infant Development is an individualized service that is delivered on a one to one basis professional to participant.

Infant Development is a home-based, family focused service that provides information, support and training to assist the primary caregiver(s) in maximizing the child's development utilizing a parent-coaching model. Infant Development professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. The title of the participants plan for children under age three and receiving Infant Development services is called the Individualized Family Service Plan (IFSP). This Team determines services necessary to meet the child and caregiver needs, along with the frequency and duration of services.

Home visit: Home visits allow an opportunity for professionals from the Team to coach the primary caregiver (s) in how to address the identified needs most effectively for their child. The team will determine the frequency of home visits and should change the frequency based on the needs of the child and family. Home Visits must be scheduled for at least once a month, but may be scheduled for multiple times a week. The expectation is that home visits will last about an hour.

Consults: Consults allow the opportunity for other members of the Team to coach both the primary caregiver(s) and home visitor in the area of their specialty. The IFSP outcomes determine the frequency of consults needed to meet the outcomes. The team will determine the expertise needed and what areas of consult are required to meet the child and family's needs and IFSP outcomes.

Evaluation/Assessment: An evaluation is completed to determine eligibility for Developmental Disabilities Program Management (DDPM), as well as for Infant Development services, when a child applies for services. An assessment is completed annually, after a child is eligible for services, to determine progress made on the IFSP outcomes, as well as to offer information for updating the IFSP, which is completed annually. Evaluations and Assessments must be conducted by at least two qualified ID personnel of different disciplines (either contracted or employed) from the Core Evaluation/Assessment Team.

IFSP Development/Update: The IFSP directs supports and services, in relation to the prioritized concerns and outcomes of the primary caregiver(s) and rest of the Team. Initial meetings must take place within 45 days from referral. Annual meetings must occur annually, 1 year minus 1 day from the date of the last meeting. Periodic reviews must occur at least every 6 months, however, can be more frequent to address child and family needs/concerns. Reviews must be done as a result of discussion and agreement of all team members.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Infant Development serves children birth through 2 years of age as they are not eligible for special education services available for children eligible for Part B-619 of IDEA offered through the North Dakota Department of Public Instruction. This service cannot be accessed at the same time as Part C funded services thru IDEA.

Infant Development does not provide direct therapies nor can it be provided at the same time as other waiver services.

Home visits cannot be conducted over the phone.

Nursing consultations can only be billed when needed to ensure the child's health and welfare while participating in another Early Intervention service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Infant Development

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
Licensed according to NDAC 75-04-01.
Certificate *(specify):*

Other Standard *(specify):*
Infant Development programs must provide services according to the prescribed delivery model and cannot offer other models, including direct therapy to infants and toddlers.

The prescribed service delivery model is based on research showing that infants and toddlers do not learn in massed trials, but through natural learning opportunities that occur throughout the day. Infant Development is an individualized service that is delivered on a one to one basis professional to participant. Infant Development professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. The Team determines services necessary to meet the child and caregiver needs, along with the frequency and duration of services.
Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Parenting Support

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Parenting Support assists participants who are or will be parents. Parenting Support is different from family support programs as the eligible individual is the parent. In family support programs the eligible individual is the child.

Parents receive parenting skills training that is individualized and focused on the health and welfare and developmental needs of their child. Close coordination is maintained with informal supports and other formal supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Support is available from the first trimester until the eligible participant's child is 18 years of age.

Parenting Support is limited to an average of four hours of individualized child-focused direct training per week during a quarter.

This service is not available if Residential Habilitation is authorized. If the eligible participant (parent) does not have physical custody or visitation rights, they will not receive individualized child focused training, but group training and support activities are provided.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Parenting Support

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
According to NDAC 75-04-01. Licensed to provide family support programs or Infant Development
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Medicaid Agency, DD Division
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation Costs for Financially Responsible Caregiver

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Funds for this service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to prevent out of home placement of minor children who are living in their primary caregiver's home. Transportation costs for Financially Responsible caregiver include expenses such as mileage, lodging, etc. incurred by family members related to accessing supports identified in the participants plan. Lodging for the participant and/or accompanying caregiver is only allowed when medically necessary or cost effective and the reimbursed amount will not exceed allowed state rates which for out of state travel are based on Medicaid State Plan reimbursement rates. Lodging will not be reimbursed without a receipt.

All associated costs (i.e. mileage, lodging, meals) must be authorized before reimbursement for transportation can occur. The authorization is a part of the participants planning process. The authorization is also approved by the DD Division.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limited to $5,200 per State Fiscal Year per participant.

Out-of-state mileage included in the participant's authorization is determined between the participants dwelling and the city where services are accessed.

In-state mileage through this service is reimbursed after the first 150 miles are incurred in each month.

A table is developed with Department of Human Services Medical Services Division to clarify when transportation as a waiver service can be accessed and when transportation is reimbursed through the Medicaid State Plan. The table is distributed to County and Program Management staff. Transportation reimbursement does not duplicate other transportation that may be provided through other waiver services or the State Plan.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation Costs for Financially Responsible Caregiver

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Vaild Driver's License and required insurance
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Agent will verify that lodging, meals and mileage does not exceed the amount of the submitted receipts and the total requested does not exceed the amount authorized by the DDPM.
Frequency of Verification:
Annually review of the drivers license and insurance. Fiscal Agent will verify expenditures and provider qualifications per contract requirements.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DD Program Management through the Regional Human Service Centers which are under the umbrella of the Department of Human Services.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

As provided by NDAC and DD Division policy, criminal background checks must be conducted on all prospective employees of licensed DD provider agencies who may have direct access to individuals served. This includes direct care positions, administrative positions, and other support positions that have contact with individuals served. When prospective employees have lived in North Dakota for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.

The DD Division reviews any record of a criminal conviction of an applicant to determine if according to NDAC the individual is eligible to be considered for employment by a licensed DD provider.

Upon annual reapplication for license renewal, the applicant agency submits a listing of each current employee with any new criminal convictions, the date of the conviction, and nature of the offense. If the offense is a direct bearing offense, the DD provider is notified that the employee cannot provide services to the DD participant.

Employees hired by families for self-directed In-Home Support services have background checks completed by the Fiscal Agent.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DD Division policy requires that providers conduct a check of the Child Abuse and Neglect Registry for each employee hired. The Child Abuse and Neglect Registry are maintained by the ND Dept. of Human Services Children and Family Services Division. An abuse registry is not maintained specifically for providers of waiver services.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	C
Residential Group Homes	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Group homes with four or more beds allow participants to live in residential neighborhoods in the community. Meals are served family style and resident's access community activities, employment, schools or day programs. Per NDAC it is the policy of the state to assure basic human rights to each participant of a facility. These rights include the right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Infant Development	☐
Residential Habilitation	☑
Transportation Costs for Financially Responsible Caregiver	☐
In-Home Supports	☐
Environmental Modifications	☐
Behavioral Consultation	☐
Adult Day Health	☐
Family Care Option	☐
Homemaker	☐
Parenting Support	☐
Day Supports	☐
Extended Services	☐
Extended Home Health Care	☐
Equipment and Supplies	☐
Adult Family Foster Care	☐

Facility Capacity Limit:

Eight

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	

Standard	Topic Addressed
	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

N/A

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives who are not legal guardians and not living in the same home as the eligible participant may be paid for providing waiver services if they meet all other requirements.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Enrollment is open to all entities that meet the licensure requirements. NDAC details the requirements, application process and appeal rights. Application materials are available on request or on-line.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State□s quality improvement strategy, provide information in the following fields to detail the State□s methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(C-1) Number and percent of providers, subject to licensure, meet North Dakota's state law and adhere to other standards prior to furnishing waiver services. N:

Number of providers, who met ND's state law and adhered to other standards prior to furnishing waiver services. D: All provider applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Licensed Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(C-2)Number and percent of new self-directed service (SDS) In-Home Support employees, who have met ND State requirements. N: All new SDS In-Home Support employees have met State requirements. D: All new SDS In-Home Support employees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Agent Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Agent	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-Annually

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(C-3) Number and percent of family In-Home Support members who report that staff hired meet minimum client specific competencies identified in the participants plan. N: Number of SDS-IHS family members who report that IHS staff hired meet minimum client specific competencies. D: All SDS-IHS participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Web based data system

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

(C-4) Number and percent of provider agencies, whose staff complete State required training. N: Number of provider agencies, whose staff completed State required training. D: All provider agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
All DD providers are required to initially enroll and re-enroll every year. The DD providers are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a DD provider. DD Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State□s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DD Division is responsible for licensing all DD Providers. Individual provider problems are addressed in writing with the provider and may include one on one technical assistance, requests for additional information, clarification/ rewriting licensing documents and instructions, monitoring and termination of the DD provider who fails to re-license or no longer meet the DD provider standards or qualifications.

The DD Division staff is responsible to address any complaints received. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

(C-1) When standards aren't met, applicant has option to resubmit deficient areas or withdraw application.

(C-2) The DD Division reviews the Fiscal Agents report to determine if the ND State requirements were met. If upon review a criterion was not met, the DD Division will inform the Fiscal Agent that payment cannot be made to the self-directed employee until the ND State requirement is met.

(C-3) The DDPM updates the participants plan showing that staff hired meets minimum client specific competencies according to the families' standards.

(C-4) Training contractor sends out a list of provider staff that has not completed their training as required and the provider needs to provide information on how this is going to be remediated. Salary is not increased until training requirements have been completed.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Department has done a review and analysis of all settings (residential & nonresidential) where HCB services are provided to eligible clients. The analysis included review of ND Century Code, ND Administrative Code, policy, and review of licensing rules, regulations and documentation.

Through this process the state has determined the following waiver services fully comply with the regulatory requirements because they are individualized services provided in the recipient's private home and allow full access to community living according to their needs and preferences. Recipients or their primary caregiver get to choose what services and supports they want to receive and who provides them. Recipients, who are age-appropriate, are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.

Fully Complaint HCB Waiver Services:
• Behavioral Consultation
• Environmental Modifications
• Equipment and Supplies
• Extended Home Health Care
• Family Care Options
• Homemaker Services
• In-Home Supports
• Infant Development
• Parenting Support
• Transportation Costs for the Financially Responsible Caregiver

The Department will assure continued compliance with the HCB settings rule by implementing and enforcing policy that will assure the continued integrity of the HCB characteristic that these services provide to waiver recipients. In addition, the State monitors all individual care plans, conducts case management reviews, client interviews/ quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Overall Service Plan (OSP)/Individualized Family Support Plan (IFSP). The State is in the process of moving toward utilizing the title of OSP for all participant plans. However, at this point the current protocol refers to the separate titles for varies service populations (e.g. IFSP for Early Intervention Services/ID services).

a. **Responsibility for Service Plan Development.** Per 42 CFR 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Qualified Developmental Disabilities Professional (QDDP formerly QMRP) is an employee of the state Medicaid agency responsible to authorize the DD waiver services including the amount, frequency and type of provider. This information is contained in the individual service plan section of the overall plan.

- [ ] **Social Worker**

Specify qualifications:

- [x] **Other**

Specify the individuals and their qualifications:

For Residential, Day Habilitation, Infant Development, In-Home Support, Family Care Option and Parenting Support services staff of DD licensed providers of waiver services is responsible for the person center service planning component and delivery of wavier services.

For self-directed services (Behavior Consult, In-Home Support, Environmental Modification, Equipment & Supplies, and Transportation for Financially Responsible Caregiver, Extended Services), AFFC, Extended Home Health, HM, and Adult Day Health the DDPM is responsible to develop the service plan.

Staff for Infant Development staff is primary early intervention professionals are all licensed in their profession of of early childhood special education, occupational therapy, physical therapy, speech language pathology, and nursing.

For all other waiver services staff is QDDPs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Safeguards to ensure that the participants plan development is conducted in the best interest of the individual are evident when an individual or their legal decision maker chooses a service provider from a list of all qualified providers. A list of qualified providers will be given to the waiver participant and/or their legal

decision maker at the time of waiver enrollment and annually thereafter or whenever the participant voices a complaint or concern. The list will be contained in a packet which also includes additional rights of the participant including a rights and responsibilities brochure, contact information for the DDPM, the appeals supervisor (to request a Fair Hearing).

Once an individual or their legal decision maker selects a provider they acknowledge that they made an independent choice when signing the Individual Service Plan (ISP). The right to a choice of service provider is printed at the top of the ISP document along with other participant rights. The plan developed by a service provider must be approved by the participant and the DDPM who is employed by the state Medicaid agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

All waiver participants and/or legal decision makers are active participants in the service plan development. The DDPM provides written information to all waiver participants and/or their legal decision maker that describes their right to direct and be actively engaged in the development or the participant plan, including their right to determine who is included in the process. This will be included in the rights packet of information that will also describe the services available, their rights and responsibilities including their right to choose between and among waiver services, service providers and the right to request a Fair Hearing. The DDPM provides this information to the participant and/or legal decision maker at the time of waiver enrollment and whenever a participant signs the ISP. The rights are included at the top of the document.

In addition, a self-assessment, or in the case of infants and toddlers, a routines-based interview is conducted with the participant and/or legal decision maker prior to each annual service plan that identifies personal goals, preferences, and outcomes that may be incorporated into the plan. The participant and/or legal decision maker is given the opportunity to determine a convenient date, time and location for the development of the plan. Once the plan is developed, the participant and/or legal decision maker signs that they are in agreement with the plan.

The participant and the people they select to participate are encouraged to lead and direct the design of their service plan including facilitating the team meeting if they desire.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)Who develops the plan, participants and timing of the plan:

The DDPM or qualified staff from a DD licensed provider assists the participant and/or legal decision maker in identifying the participants they wish to involve in the process of their plan and to determine a date and time that is convenient for the participant in developing the plan.

In addition to the individual, legal decision maker, DDPM and service provider, additional planning team members may include family, friends, advocates and other community supports. Staff members who work most closely with the individual providing direct support and care, and know the individual best are encouraged to participate and will

be invited to participate if the individual/legal decision maker agrees.

The plan is developed at the time the participant starts waiver services and is updated at least annually. The plan is reviewed and revised when the participant needs change between the annual plan.

(b) Assessments:

A variety of assessments are completed to support the planning process including but not limited to:

Often referred to as a "self-assessment" or for infants and toddlers a "routines based interview" this involves what is most important to the individual from their perspective and the perspective of others that care about the individual. It involves identifying the individual's strengths, preferences, and needs through both informal and formal assessment process. Risk Assessment: This assessment assists the individual and the team in identifying significant risks to the participant's health and safety. Health Assessment: Physician, psychiatric, other health specialties, Assessment of Adaptive Daily Living Skills, Individual Adaptive Daily Livings Skills, social skills.

(c) How the participant is informed of services under the waiver:

Prior to waiver enrollment the DDPM meets with the participant and/or legal decision maker to discuss what the participant wants regarding services and supports and what they expect. The DDPM explores potential services offered through the waiver, Medicaid State Plan, and other community resources and natural supports that might meet their needs. A list of services is provided along with the qualified providers of the services. The DDPM also reviews this information at least annually during the annual planning process and during the service monitoring process throughout the year.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

The web based application includes service plan template(s) that require the team to include the participant’s self-assessment (goals and preferences), risk assessment (health and safety needs and mitigation strategies), strengths and areas of needs in ADLs, IADLs, and health status including diagnosis, health information and required supports, such a physician recommendations, nursing assessments, OT, PT, speech therapy, vocational, psychology/behavior analysis, leisure, recreation, or other evaluations as needed for the participant.

(e) How waiver and other services are coordinated:

The DDPM is the lead in assisting the participant and\or legal decision maker in coordinating the services through the service planning process. The planning process identifies natural supports, waiver supports, Medicaid State Plan and other generic community supports regardless of funding source. These services are listed in the participants plan.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

The plan identifies the provider of each service and the plan authorization identifies the amount/frequency of each service. During the team meeting the assignment of responsibilities is discussed and documented.

The day to day monitoring and implementation of the plan is the responsibility of the DD licensed provider and the participant and/or legal decision maker. DDPM is responsible for in-depth monitoring every six months including face to face visits quarterly.

(g) How and when the plan is updated/changes to the plan

The plan is updated at least annually.

Whenever there is a change in the participant’s needs, the team is required to review the risk assessment and service plan and make the appropriate revisions. Changes in the participant’s needs may include but are not limited to: a change in medical/behavioral status; specific incident, hospitalization; nursing facility stay; prior to a service change; prior to a change in service location, or change in outcomes/goals.

A plan update may also occur subsequent to the DDPMs face to face visit and contact with the legal decision maker. The face to face visit\contact with legal decision maker occurs approximately every 90 days as part of the quality enhancement review process and monitoring of the services and plan.

The participant/legal decision maker can request a or review the plan at any time.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The initial risk assessment instrument is completed by the DDPM prior to waiver enrollment. When services are selected the risk assessment is reviewed by the team and the strategies to mitigate the identified risks are incorporated into the service plan.

At least annually or as needed, the team reviews the risk assessment as part of the service planning process and develops the strategies to mitigate the identified risks that are incorporated into the service plan.

The back -up plans are developed during the team planning process. The plans include arrangements for short and long term alternatives in the event the caregiver and/or services cannot be delivered. Emergency back-up plans vary depending upon the individual circumstances and may include names, phone numbers of emergency contacts, description of participant routines and needs, who will provide alternative care and services, and where the plan is located.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The DDPM provides the participant/legal decision maker with a list of qualified service providers upon enrollment in the waiver and upon request. The right to choose their qualified provider(s) is listed at the top of the service plan which is signed by the participant/legal decision maker at least annually or whenever there is a change in services.

The participant may choose to be referred to one provider or multiple providers. The DDPM assists the participant in arranging for interviews of potential providers and touring program sites selected by the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The DDPM, an employee of the State Medicaid agency, is responsible to ensure that the plan contains all required components (i.e. individual's current status, strengths and support needs, specific outcomes and goals, learning and support objectives, risks and mitigation strategies, health needs, safeguards and financial benefits)and approves all waivered services in the plan.

A sample of the service plans are reviewed by the State DD Division as part of the human service center and provider licensing process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR □92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The DDPM is responsible for the monitoring of the implementation of the service plan and participant health and welfare.

The DDPM has direct oversight of the plan to assure that services are furnished in accordance with the services authorized. The DDPM ensures services meet the participant's needs, back up plans are effective, participants exercise their choice of provider, and access to health services identified in the plan.

The DDPM is responsible to conduct face to face visits with the participant approximately every 90 days in the setting in which the waiver services are delivered. The DDPM reviews progress toward outcomes, determines the participant's satisfaction with services and addresses any concerns.

The DDPM is notified of alleged incidents of abuse, neglect and any serious events via the incident management system and is responsible for follow up to ensure the individual is safe and actions have been taken to minimize the chance of the incident reoccurring.

The DDPM reviews the participant's plan, observes interactions with staff and documentations to assure the plan is implemented as written. The DDPM has contact with the legal decision maker approximately every 90 days to address service satisfaction and any issues related to service delivery including response to incidents, amount and frequency of service if applicable, care and treatment, and the service plan in general. Any identified problems that require action will be addressed and documented in the progress notes. The Quality Enhancement Review (QER) summarizing this information is completed at least every 6 months.

Issues that cannot be resolved at the DDPM and provider level are reported to the Regional DD Program Administrator and/or the State DD Division for remediation. In addition, a sample of the QERs and monitoring results are reviewed by the State as part of the human service center and provider licensing process.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State□s quality improvement strategy, provide information in the following fields to detail the State□s methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants□ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-1) Number and percent of participant plans that include strategies to address needs and mitigate risks identified through the assessment process. N: Number of participant plans that included strategies to address needs and mitigate risks identified through the assessment process. D: Total number of plans reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Interval, +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant□s needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-2) Number and percent of the participant plans are updated annually. N: Number of participant plans updated annually. D: Total number of plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Web based data system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-3) Number and percent of participants who receive the services in their plans. N: Number of participants and/or legal decision makers who report they did receive the services in their plan. D: All participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Enhancement Review (QER) through the web based data system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(D-4) Number and percent of participants who have a signed ISP, stating that they have chosen between waiver services and providers. N: Number of participants who have a signed ISP, stating that they have chosen between waiver services and providers. D: All participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual Review (licensure)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Interval, +/-5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State□s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DDPA/DD Division reviews any areas of noncompliance identified in the record review, for the sample. Any areas of noncompliance are addressed by the DDPA, with the respective DDPM and the results will be reviewed with DD Division. Any deficiencies require a corrective action plan within the HSC administrative code. Follow up is completed per DD Division policy.

(D1)The DDPA/DD Division reviews the assessments, in the sample, and ensures that all identified needs and risks are mitigated. The DDPA addresses any unmitigated needs and risks with the respective DDPM. If a participants plan needs to be updated, a Team meeting is held as specified by the DD Division policy. The DDPA verifies that corrections are made.

(D2) An alert is generated within the web based data system, 90 days prior to expiration date of Service Plan. A report is generated of all late Service Plan to regions and requires correction for those that are late and still outstanding, per DD Division policy. The DD Division follows up, by generating another report, to ensure correction are made timely. At the time of the licensing review, patterns and trends of late Service Plans can result in a deficiency and require a corrective action plan.

If any of the required elements of the plan are not completed, the plan is updated, per DD Division policy. The DDPA verifies that corrections are made.

(D3) The DDPM identifies in the QER, why DD authorized services weren't delivered in accordance with the Service Plan and describes the plan to address and remediate any undelivered services, to include expected implementation date. The DD Division distributes a report, per DD Division policy, to regional DDPAs for any QERs noting follow-up is needed. DDPAs review and address identified undelivered

services and ensure completion of follow-up.

(D-4) Upon notification that a participant did not receive a choice of waiver services or providers, participant has a right to appeal. At the time of the licensing review, signed ISP is reviewed for completion. Any deficiencies require a corrective action plan within the HSC administrative code. Follow up is completed per DD Division policy.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants determine the vendors/providers from whom they will purchase services and supports. They will also negotiate the cost. Participants will have the opportunity to determine their priorities within the waiver budget limitations. DDPMs and Fiscal Agent staff will support participants as they self-direct. Information regarding risk and responsibility involved in self-direction, recommendations and considerations when selecting a vendor is provided in writing for participants and the material is reviewed with them. Guidance regarding key decisions and assistance in prioritizing needs will also be offered.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**

- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Self-directed services consist of Behavior Consultation, Environmental Modifications, Equipment and Supplies, and Transportation Costs for the Financially Responsible Caregiver. These services are, solely, participant-directed. In-Home Supports and Extended Services can be either participant-directed or provider managed.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Discussed at intake, prior to enrolling in the waiver, and annually during the team planning process, the DDPM provides the following information to the participant and\or legal decision maker:
a. description of benefits and potential liabilities associated with participant direction of services;
b. responsibilities of participants;
c. support and information available through DDPMs and the Fiscal Agent;
d. components of the participant service plan and their responsibility in its development.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Transportation Costs for Financially Responsible Caregiver	☐	☑
In-Home Supports	☑	☑
Environmental Modifications	☐	☑
Behavioral Consultation	☐	☑
Extended Services	☑	☑
Equipment and Supplies	☐	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Contract Entity applying the North Dakota policies for the procurement process.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Monthly fee for service

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The DD Division has frequent (at least every quarter) conference calls with the Fiscal Agent to review issues identified through data analysis of the QER. The authorization process prevents over payment to the Fiscal Agent as the MMIS payment system has edits that prohibits payments in excess of authorized budget limits. The DD Division Staff monitor monthly budget program spend down reports generated through MMIS payment system and monthly contract billings for Fiscal Agent services. As outlined in the contract with the Department, the Fiscal Agent has an independent audit conducted and shares the results.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Infant Development	☐
Residential Habilitation	☐
Transportation Costs for Financially Responsible Caregiver	☐
In-Home Supports	☐
Environmental Modifications	☐
Behavioral Consultation	☐
Adult Day Health	☐
Family Care Option	☐
Homemaker	☐
Parenting Support	☐
Day Supports	☐
Extended Services	☐
Extended Home Health Care	☐
Equipment and Supplies	☐
Adult Family Foster Care	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Qualified Developmental Disability Professionals, employed by the Department of Human Services, at the Regional Human Service Centers, provide program management. This is claimed as an Administrative Activity.

DDPMs meet with the participants and/or legal decision makers to review information regarding the roles, risks, and responsibilities involved with self -directing supports. The DDPMs connect them to the Fiscal Agent, provide practical skills training to assist them with directing services, assist them with locating sources of waiver goods and services and developing budget management skills.

The DD Division conducts annual licensing reviews of the activities of the DDPMs. The reviews include compliance with established protocols and policies regarding program management activities.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The DDPM informs the participant and/or legal decision maker of the availability of representation from the ND Protection and Advocacy Project. If requested, the DDPM will assist participants in accessing services with the ND Protection and Advocacy Project. The availability to contact Protection and Advocacy Project is also printed at the top of the individual service plan that is signed by the participant and/or the legal decision maker. The Protection and Advocacy Project does not furnish other direct services or perform waiver functions.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The DDPM reviews the ramifications of voluntary termination, including possible impact on Medicaid and health and safety issues for the eligible participant. Other support options including Medicaid State Plan services and other waivers are explored. The DDPM assists the participant and/or legal representative in transition activities. Waiver services continue during the transition period.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the roles and responsibilities identified in the participants plan are not carried out and it is directly impacting the health and safety of the eligible participant, the DDPM notifies the participant that services are being terminated and review their right to appeal the termination of services offered through this waiver. Other support options including Medicaid State Plan services and other waivers are explored. The DDPM assists the participant in transition activities.

The Participant Agreement and the Budget Authorization for self-directed services describes circumstances under which the services are terminated. Services will be terminated if the parent or legal guardian is unable to self-direct services which results in a situation that jeopardizes the participant's health and welfare, Medicaid fraud, the participant is no longer eligible for Medicaid or ineligible for ICF/IID level of care. Services will continue during the transition unless there are situations that immediately impact the health and safety of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		510
Year 2		535
Year 3		560
Year 4		585
Year 5		610

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Providers are licensed through the ND Department of Human Services to provide family support services or and Extended Services. Licensed providers are vendors with the Fiscal Agent. To assure individuals/families maintain control and authority over employees, and that the family support service provider supports the concepts of self-direction, specific roles and responsibilities are addressed in the participants plan.

DDPM's are responsible to assist the participant in plan development and ensuring the qualifications for staff are meeting the family's guidelines as described in the plan. Family satisfaction with staff is reviewed at least quarterly.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [ ] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Team discusses potential outcomes and service needs for a participant. If self-directed services are recommended, the participant completes the application process. Through the application process generic and informal resources are discussed with the family to determine if there are any natural supports or other community supports available to meet the family's needs which would negate need for waiver services.

Service delivery is dependent upon outcomes identified in the team planning process after family has prioritized need. An application has been developed and is utilized upon entry into waiver service and annually thereafter. The application assists the family in identifying need areas and assists the DDPM in determining the excess.

After the participant and/or their legal decision maker have completed the In-Home Support and\or Disability Related Supports application, the DDPM develops the individualized budget. The budget is based on the specific support needs of the eligible participant, generic and informal resources available, and risk of unwanted out-of-home placement. Individualized budgets identify the funds that will be available for each budget line item. The amount authorized for other self-directed supports are negotiated based on anticipated costs.

Transportation reimbursement will be projected based on state guidelines.

Participants and/or their legal decision makers sign all individualized authorizations to indicate their approval and acknowledge their right to appeal. All individualized authorizations are also reviewed by the Regional DD Program Administrator and must be approved through the DD Division before services can begin. All authorizations are reviewed after the quarter to audit the authorization back to the actual amount of funds utilized. This information is then considered as the next authorization is developed.

The fiscal agent has information available on their website that the DDPM directs participants to and the public has access to.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants and/or their legal decision maker signs all individualized authorizations which identifies services and services amounts authorized to indicate their approval of the projected budget and acknowledge their right to appeal. The budget is only authorized after the participants plan is developed.

Quarterly, the DDPM reviews with the participant and /or the legal decision maker if the services continue to meet their needs. If during the authorization period additional funds are needed to ensure the health and safety the participant, the family will request a meeting with their DDPM to renegotiate their budget.

The participant is informed of the opportunity to request a Fair Hearing when a request for a budget adjustment is denied or the amount of the budget is reduced through the Budget Authorization form. The participant signs this form before services can begin. Every authorization includes a statement informing the participant and/or the legal decision maker on steps to take regarding disagreement with the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DDPMs inform participants and/or legal decision makers that due to the nature of the program being self-directed; it is the participant's responsibility to utilize their authorized services based on their need. This is discussed prior to service provision.

The Fiscal Agent has an on-line budget balance sheet that indicates total budget, percentage of expenditures and remaining funds. This information is available to the DDPMs and participants. The participants and/or their legal representatives receive the same information as payments are made or on a monthly basis if requested. The fiscal agent provides the participant and/or legal decision maker with a monthly statement showing service utilization. The participant and/or legal decision maker can monitor the monthly statement. Participants and/or their legal representatives may also call the Fiscal Agent for updated information.

The primary responsibility lies with the participant, and/or the legal decision maker, and the utilization of the monthly statement from the fiscal agent. Families have the opportunity to express concerns quarterly with the DDPM.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the

request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR 431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When applicants have expressed interest in services the DDPM meets with them to complete intake activities and explore potential service options. At this time the DDPM also informs them in writing of the grievance procedures which includes their right to a fair hearing.

At the top of each service plan that is signed by the participant and/or legal decision maker the following rights are listed: the right to request a fair hearing. If they are not given the choice of Home and Community Based Services as an alternative to institutional care, are denied the service(s) of their choice, or the providers of their choice; or whose services are denied, suspended, reduced or terminated. Notification of Rights at a minimum are provided to each waiver participant by the DDPM at enrollment, during the development of the participants annual plan process, and whenever a participant registers a concern regarding services.

The participant and\or legal decision maker may contact the DDPM for instructions on how to request a hearing. The participant and\or legal decision maker must request a hearing in writing within 30 days of the date of the written notice. Hearing requests must be forwarded to: Appeals Supervisor, North Dakota Department of Human Services. The participant and\or legal decision maker may represent themselves at the hearing or they may have an attorney, relative, friend or any other person assist them. If the participant and\or legal decision maker request a hearing before the date of action, ND DHS will not terminate or reduce services until a decision is rendered after the hearing, or the participant and\or legal decision maker withdraws the request for a hearing, the participant and\or legal decision maker fails to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. The participant and\or legal decision maker is advised, however, that if the hearing decision by the Department of Human Services is not in their favor, the total additional amount paid with Medicaid funds on their behalf may be considered an overpayment subject to recovery.

In addition authorizations for all In-Home Support, Family Care Option, Family Care Option III and self- directed services provide quarterly notice of rights to appeal adverse actions regarding reduction, denial, or termination of services. Families must sign and return the authorization on a quarterly basis prior to services being initiated for that quarter. DDPMs mail the authorization to families and are available to assist the family with questions concerning exercising their rights.

DDPMs keep copies of correspondence regarding Notice of Adverse Actions, signed ISPs and Authorizations at the Regional Human Service Centers.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - ○ **No. This Appendix does not apply**
   - ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

   The participant and \or legal decision maker may request an informal conference to dispute a denial of services, termination, reduction or suspension of services, choice of provider, and choice of HCBS versus institutional care, The use of informal conference will not preclude or delay the individual's right to a fair hearing.

The request for an informal conference must be submitted to the Regional Human Service Center Director within 10 days after the written notice of the determination. The Center Director shall within five working days of an oral or written request for an informal conference convene a conference with the aggrieved party. Within five working days after the informal conference the Regional HSC Director will issue a written decision.

The DDPM provides assistance to the aggrieved individual in the informal and formal appeal process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The definitions for Abuse, Neglect and Exploitation and the role of the Protection and Advocacy Project are defined in North Dakota Century Code 25-01.3. Definitions for child abuse and neglect for individuals under the age of 18 and the role of Child Protective Services are contained in NDCC Chapter 50-25. l Child Abuse and Neglect. In

addition, the Developmental Disabilities Division has developed policies and procedures for entities that provide services to waiver participants regarding the reporting and follow up of Serious Events including abuse, neglect and exploitation. Providers of home and community- based waiver services are required to report serious events and alleged abuse, neglect and exploitation.

All Serious Events (unplanned hospitalization, death, unauthorized restraints, and alleged sexual abuse/contact) are reported to, and assessed by an independent third party. For participants age 18 and older, the Protection and Advocacy Project (P & A) will be responsible to receive the reports, assess the need for further follow up and conduct the investigation if indicated. If the participant is under the age of 18 years, Child Protective Services also receives the report and may take the lead in assessing the need for follow up and investigation. If CPS chooses not to investigate, P & A will then assess.

When the event is a participant death, the service provider provides verbal notification to the Regional DD Program Administrator and State DD Division within one working day. A written report must be submitted within 7 working days to P&A, Child Protective Services (if appropriate) Regional DD Program Administrator, and State DD office.

All incidents that do not meet the criteria for a Serious Event are reviewed by the service provider utilizing the "Reporting Determination Guidelines" that are contained in DD Division policy. If the incident meets any of the guidelines, the service provider is required to implement appropriate risk management and report the incident to P&A, the Regional DD Program Administrator and the State DD Division within one working day. Investigation and follow up is determined by DD Division policy. If the individual is under the age of 18, the service provider will notify Child Protective Services (CPS). The service provider is required to notify the legal decision maker of the incident provided that the legal decision maker is not the subject of the report.

For provider managed services the provider will complete a State Form Number 960 to report the alleged abuse or neglect of a child to Children and Family Services and a general event form (GER) into web based data system to notify the P & A, DDPM, and the DD Division per DD Division policy.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DD Program Managers provide participants and their legal decision makers with written information regarding the "DD Bill of Rights", ND Century Code 25-01.2 and definitions of abuse, neglect and exploitation. The information will be presented at a level consistent with the individual's level of understanding and will include contact information to make a report. This information will be provided at the time of waiver enrollment and reviewed annually thereafter. Individuals who are in need of self-advocacy training per risk assessment receive self-advocacy training as part of their plan.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receipt of the report, P&A or CPS determines if the incident requires follow up by an independent third party. If it is determined that the incident does not meet the criteria for serious event and/or does not require investigation by an independent third party, the service provider conducts an investigation within 5 working days of being informed that it doesn't require an independent investigation and submit their findings to P&A, the Regional DD Program Administrator and the State DD Division. The specific requirements for the investigation are described in DD Division policy.

Upon receipt of the service provider's investigation report, P&A submits a Letter of Findings indicating whether or not the incident is substantiated as abuse, neglect or exploitation and any recommendations for follow up. All investigations and findings are reviewed by DD Division staff.

The Regional DD Program Administrator, the individual's DD Program Manager and the State DD Division review all reports and assessments completed by the service provider. The DD Division shall determine if additional information or reporting is required and may impose corrective measures upon the service provider. There may be situations when regional DD program management staff, State DD Division, P&A, and CPS may conduct a joint

review.

In all cases, the DDPM follows up on any reports during their quarterly in-depth monitoring to verify that the recommendations and plan to prevent reoccurrence was implemented. The DDPM discusses the incident and findings with the participant and/or legal decision maker to address any additional areas of concern during the Quality Enhancement Review (QER) process/ in-depth monitoring. Follow up related to the incident will be documented in the QER progress notes. The DD Program Manager will assist the individual or decision maker to address unresolved concerns with the service provider, and if necessary the State DD Division and P&A.

For individuals under age 18, suspected abuse, neglect, and exploitation (ANE) is reported to Child Protective Services (CPS) who is responsible for assessment/investigation and follow up relative to the report. Reports should be made to the county social service office where the child is currently physically present.

For individuals under the age of 18, for provider managed services, providers must report to CPS as well as P & A within 24 hours of the serious event or ANE occurring or as soon as known.

When a report involving an individual age's birth to 18 is made to Child Protective Services the CPS worker must begin an assessment within 24 to 72 hours. The timeline will depend upon the nature and seriousness of the report as defined in protocol. The CPS worker is required to make a face-to-face contact with the child within 24 hours, 3 days or 14 days which is dependent upon the nature and seriousness of the report.

The written assessment/investigation with accompanying documentation must be completed and submitted to the regional child protection supervisor within 62 days unless an extension is requested and approved by the regional child protection supervisor.

The CPS worker must conduct a face-to-face meeting with the child (subject of the report) within the 62 days of the assessment period.

The Child Protection Social Worker completing the assessment of a report of suspected child abuse or neglect shall provide notification of the case decision to, the subject of the report. When the case decision is "Services Required", the notification to the subject shall be made face-to–face. If a face-to –face notification cannot be done, the reason needs to be documented. When the case decision is "No Services Required", the notification may be made either face-to- face or by telephone. Written notice of the case decision is also made to the subject of the report and to the parent(s) of the child(ren). Out of respect for the families involved in the assessments process, the report needs to be completed as soon as possible and notification be made to families of the decision. There is not a specific time frame established for this notification. For incidents that do not meet child protective services criteria, the report would be referred to P & A or Law enforcement may also be a referral depending upon the concerns reported.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

All reports and findings submitted to the DD Division for serious events and all other incidents reported as abuse, neglect and exploitation are entered into an Incident Management data base maintained by the State DD Division.

In addition, monitoring of all service providers is conducted biannually by State DD Division and P&A staff. The monitoring includes a sample review of incident reports to determine if the service provider is reporting serious events as required, or utilizing the reporting determination guidelines and conducting investigations as indicated in DD Division policy.

When it is discovered that a child is receiving DD services, and is the subject of a Suspected Child Abuse and Neglect allegation, the Child Protective Service supervisor and Regional DD Program Administrator at the Regional Human Service Center will be notified. Child Protection Services will assess and investigate according to NDCC Chapter 50-25. l (Child Abuse and Neglect). Regional Human Service Center DD Unit will provide assistance with such issues as whether or not the child's condition may be a contributing factor to the report, what services may be available to assist the child and family, or what services may be available to the child if out of home placement is required.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All service providers must have written policy and procedures concerning behavior intervention and emergency procedures for controlling maladaptive behavior and must provide for a Behavior Management Committee and Human Rights Committee. The policy and procedures must emphasize positive approaches and define and list techniques that are used and available for use in their relative degree of restriction.

Before highly restrictive emergency procedures can be implemented it is the responsibility of the planning team to perform and document a functional and ecological analysis (analyze the maladaptive behavior to determine the intent of the behavior, the antecedents of the behavior and whether environmental alterations, would reduce or eliminate it, or there is a medical cause for the behavior). The maladaptive behaviors should be targeted for reduction and the plan should specify the adaptive behaviors to replace the maladaptive behaviors. Less restrictive methods must be included in the plan and attempted prior to the application of restraint. The procedures must be designed and used so as not to cause physical injury to an individual and to minimize physical and psychological discomfort. Only a minimum amount of restraint necessary to control the individual's behavior can be used during the implementation of a restraint and used only until the individual is calm. The authorization and justification for the procedure and the period of restraint must be recorded. The restraint must be implemented only by trained staff and all protocols implemented must be documented. The emergency use of restraints must be developed with the participation of the individual served and or their legal decision maker who must consent to the program. The program using restraint must be submitted to a behavior intervention management committee and a human rights committee for review and approval prior to implementation.

Prone restraint and seclusion is prohibited per DD Division policy. Physical restraint cannot be used as a habilitative treatment or behavioral support option but may be briefly employed as a last resort in crisis situations. Planned physical restraint (personal and mechanical) can only be used in emergency situations when necessary for the control of violent and aggressive behavior which may immediately result, or has resulted in harm to that person or to other persons or the risk of significant property destruction exists.

Planned chemical restraint used to manage violent and aggressive behavior must be administered under the authorization of a licensed physician and the plan must justify the use of the drug, assure the drug is within therapeutic dosage range and will not adversely affect the therapeutic benefits of other medications. The team, including prescribing physician, must determine that the person has reached the lowest effective dosage of the medication based on data symptoms and behavior of the individual. This documentation must be in the individual's plan and reviewed by the team and physician for as long as

the person receives the medication.

Restraint (chemical, physical, or mechanical) used during the conduct of a specific medical/dental or surgical procedure, may be used only if absolutely necessary for the person's protection during the time that a medical condition exists. The physician/dentist must specify the scheduled use of restraint and its monitoring and utilization methods documented in the participants plan. The use of devices such as splints or braces, bedrails to prevent injury, wheelchair harnesses and lap belts to support a person's proper body positioning must be included in the participants plan including medical necessity and procedures for their use.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10, and DD Division policy. Waiver participants and legal decision makers must approve and agree to behavior support plans and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported.

In order to meet licensure requirements of NDAC 75-04-01-20, providers must adopt and submit policies regarding restraints and restrictive interventions to the Department for review and approval.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The established safeguards and requirements are reviewed by the team including the DDPM during the development of the participants plan. Data is compiled and reviewed at least monthly by the service provider responsible for implementation of the plan. The DDPM will review the use of individual restraints during the Quality Enhancement Review (QER) on a quarterly basis to assure the safeguards and requirements are met and to assure that the approval of the individual/legal decision maker, behavior management committee and the Human Rights Committee is documented. This information is recorded in the QER and any noncompliance or needed follow up regarding the use of restraints are initiated and documented.

The use of all unauthorized restraints (those not written into the individual's plan and approved by the Human Rights Committee and Behavior Management Committee) meet the criteria for a Serious Event and must be verbally reported to the Protection and Advocacy Project within 24 hours and a written report submitted to the individual's legal decision maker, Protection and Advocacy Project, Regional DD Program Administrator and DD Division within one working day. The Protection and Advocacy Project will be responsible for independent review and follow up.

The DD Division reviews a stratified sample of individual records and incident reports annually to assure compliance with requirements. The DD Division and Protection and Advocacy Project review the data to identify trends and patterns to support improvement strategies.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The use of aversive methods or conditioning such as application of startling, unpleasant or painful consequences is prohibited. Designated Time Out rooms are not utilized, although the use of a quiet area or an individual's private bedroom may be used for the purpose of providing the individual an opportunity to regain self-control.

The procedures for behavioral intervention should be an improvement in quality of life for the individual and should not substitute for procedures to provide positive behavioral supports. Behavior plan development includes a functional and ecological assessment, efforts to use least restrictive methods, identification of the specific problem/target behavior to be decreased and replacement behavior to be increased. Staff must be trained prior to implementation of the plan.

All methods or procedures that limit freedom of movement, access to other individuals, locations or activities or rights must be reviewed and addressed by the team and must be reviewed and approved by the individual and/or legal decision maker, the Behavior Management Committee if a behavior plan is utilized, and the Human Rights Committee prior to implementation. The participants plan must include a review schedule (minimum of annually) by the team including the individual's legal decision maker, Behavior Management Committee if a behavior support plan is in place, and the Human Rights Committee.

Monthly reviews of data will be compiled by the service provider responsible for implementation of the behavior support plan. The DD Program Manager will review the plan and data relative to the health and safety of the individual and compliance with designated protocols during the QER in-depth review conducted on a quarterly basis. This information will be recorded in the QER and any noncompliance or needed follow up regarding the use of restraints will be initiated and documented.

The use of restrictive interventions (those not written into the individual's plan and approved by the Human Rights Committee and Behavior Management Committee) or failure to implement restrictions within the parameters identified in the individual's plan as written must be reported to the individual's legal decision maker, Protection and Advocacy Project (P & A), Regional DD Program Administrator, and DD Division, and the incident investigated per DD Division policy.

Unauthorized use of restrictive interventions are required to be reported as suspected abuse, neglect, or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10, and DD Division policy. Waiver participants and legal decision makers must approve and agree to behavior support plans and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported.

In order to meet licensure requirements of NDAC 75-04-01-20, providers must adopt and submit policies regarding restraints and restrictive interventions to the Department for review and approval.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Providers are required to submit an annual report to the DD Division identifying participants who have restrictive interventions in the participant's service plan.

Reviews of data are compiled and reviewed at least quarterly by the service provider responsible for implementation of the plan. The DDPM reviews the use of individual restrictive interventions during the Quality Enhancement Review (QER) to assure the safeguards and requirements are met and to assure that the approval of the individual/legal decision maker, behavior management committee and the Human Rights Committee is documented. This information is recorded in the QER and any noncompliance or needed follow up regarding the use of restrictive interventions are initiated and documented.

The DD Division reviews the data to identify trends and patterns to support improvement strategies.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- (●) **The State does not permit or prohibits the use of seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

  The DD Division and P & A work collaboratively to review all unauthorized restraints which includes any use of seclusion. The DD Division and P & A conduct monitoring and training with DD licensed providers at least every two years and as needed. The DD Division pulls a random sample of incident reports to review which may include unauthorized restraints that have been implemented and not reported.

- ( ) **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ( ) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- (●) **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

  i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

  Individuals living in facilities or served by residential programs operated by a licensed provider:

The Developmental Disabilities Division (DD Division) through the licensing process, reviews provider policies and procedures for compliance with North Dakota Century Code (NDCC) and North Dakota Administrative Code (NDAC) regarding access to medical services and medication administration. License renewal is conducted annually for each licensed provider. Per DD Division policy a licensed provider serving non-self-medicating persons must develop written procedures approved by a licensed medical practitioner for maintaining, retrieving, and controlling access to medication.

The DD Division maintains a state wide training program currently being implemented through a contracted entity. This entity maintains a record of personnel and training which is provided to the DD Division upon request.

DD Division policy requires that non-licensed personnel administering medications to complete the medication administration module of the ND staff training system and that medication administration is delegated by a licensed medical professional. Periodic review of those personnel is conducted to determine competency to continually participate in medication administration.

Medication administration errors are subject to reporting as potential abuse, neglect or exploitation as detailed in section G-1 above. DD Division staff review all such reports and a database is maintained which can identify trends in medication administration error reports.

Individuals living in the home of a legal decision maker: Medication administration may be delegated by the legal decision maker according to competencies identified in the participants plan.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The DD Division maintains the statewide medication administration training program. Licensed nurses train personnel utilizing the ND state curricula and practica to certify individuals who have successfully completed training.

Medication errors that meet reporting determination guidelines as noted in G-1 above must be investigated and reported to the DD Division and P & A. Practices or conditions that suggest systemic issues with a providers medication administration practices must be addressed with a plan of remediation approved by the DD Division and P&A. Reported medication errors are included in a statewide abuse, neglect, and exploitation (A,N,& E) database to allow determination of trends.

In addition, monitoring of all service providers is conducted biennially by the State DD Division and P&A staff. To assess the effectiveness of training regarding Reporting Determination Guidelines, staff from the DD Division and P & A reviews a sample of incident reports for a period of at least six months to determine if targeted retraining is needed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable)

policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DD Division through the licensing process reviews provider policies and procedures for compliance with NDCC and NDAC access to medical services and medication administration. License renewal is conducted annually for each licensed provider.

The DD Division maintains a state wide training program currently being implemented through a contracted entity. This entity maintains a record of personnel and training which is provided to the DD Division upon request.

DD Division policy requires that non-licensed personnel administering medications to complete the medication administration module of the ND staff training system and that medication administration is delegated by a licensed medical professional. Periodic review for those personnel is conducted to determine competency to continually participate in medication administration.

For individuals living in the home of a legal decision maker, medication administration may be delegated by the legal decision maker.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors that meet the reporting determination guidelines are reported to DD Administrators, Protection and Advocacy Project, and the DD Division.

(b) Specify the types of medication errors that providers are required to *record:*

Licensed DD Providers are required to record all medication errors in the incident management reporting system. The types of errors recorded are as follows: a) wrong person, b) wrong medication, c) wrong dose, d) wrong time e) wrong route, f) wrong documentation, and g) missing a controlled substance.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors meeting the reporting determination guidelines are assessed by a third party for a determination of investigation or follow-up. The following is the criteria for reporting determination:

1. A medication was not administered according to doctor's orders and the participant was harmed or placed at risk of harm (including having to repeat medical treatment or medication).
2. A medical procedure was not administered or completed according to doctor's orders and the participant was harmed or placed at risk of harm.
3. A controlled substance is missing
4. A medication documentation is falsified (i.e., signing the MAR before giving the medication)
5. Professional judgment indicates a need for review (i.e., pattern of errors in a setting and/or by a staff; repeated errors for a particular participant; non-medication certified staff dispensing medications; error indicates possible systems issues, etc.)

NOTE: Risk of harm is assessed by the participant's physician, nurse, and/or pharmacist (preferably a medical person with knowledge of the participant).

If any one of the above apply, and
1. The incident could have occurred as reported (must apply)
2. If the participant is under the age of 18, contact the appropriate child protection agency
3. The incident may fall within the parameters of one or more of the statutory definitions of Abuse,

Neglect and Exploitation according to NDCC (must apply if the participant is over 18 years of age).

The error must be reported according to DD Division policy.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DD Division has the oversight responsibility for monitoring the performance of waiver providers in the administration of medications to waiver participants.

Medication errors that meet reporting determination guidelines as noted above must be documented in the web based data system. Further investigation and follow-up is determined by the DD Division and P & A. Practices or conditions that suggest systemic issues with a providers medication administration practices must be addressed with a plan of remediation approved by the Division and P&A. Reported medication errors are included in a statewide A,N,& E database to allow determination of trends.

In addition, monitoring of all service providers is conducted once every two years by State DD Division and P&A staff. To assess the effectiveness of training regarding reporting determination guidelines, staff from the DD Division and P & A assures that providers are recording medication errors in the web based data system. Additionally, in conjunction with annual provider licensure, the DD Division Review Protocol will include review by a licensed medical professional of medication administration error records and practices.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State□s quality improvement strategy, provide information in the following fields to detail the State□s methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

(G-1) Number and percent of participants who have a signed ISP, stating that they have been informed of their rights, including the right to be free of A, N and E and reporting procedures. N: Number of participants who have a signed ISP, stating that they have been informed of their rights, including the right to be free of A, N, and E and reporting procedures. D: All ISPs reviewed from sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence Interval, +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-2)Number and percent of reports where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number of assessments where abuse, neglect or exploitation are substantiated, where follow-up is completed on recommendations for waiver service providers. D: All assessments that are substantiated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracking system (PSI database)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-3)Number and percent of unauthorized restraints that were substantiated through investigation, where follow-up is completed as required. N: Number of restraints that are substantiated through investigation, where follow-up is completed as required. D: Total number of unauthorized restraints reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracking system(PSI) and web based data system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(G-4) Number and percent of substantiated choking incidents for waiver participants. N: Number of choking incidents substantiated through investigation where follow up was required. D: The total number of choking incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual review and web based data system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
To verify the accuracy of data, the number and percent of incidents that are correctly identified as reportable by providers, will be reviewed during biennial abuse, neglect, and exploitation training and monitoring by DD Division and P & A staff. Stratified samples by service type will be reviewed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State□s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DDPMs will review incident investigations and implementation of recommendations to prevent reoccurrence. Unresolved issues related to implementation will be reported to the Provider to develop a corrective action plan. If the issue cannot be resolved at this level, the DDPM will inform the DDPA and the DD Division for impact on licensure.

Quarterly meetings are held with the P & A to address review of incident report trends, training activities, incident report system policies and procedures, and results of reviews of provider internal incident practices.

(G-1) At the time of the licensing review, signed ISP is reviewed for completion. Any deficiencies require a corrective action plan within the HSC administrative code. Follow up is completed per DD Division policy.

(G-2) DD Division Staff will (monitor) work with the providers to complete mandatory training and

education up to sanctions for the waiver service providers during the certification\licensure process.

(G-3) If the follow-up was not completed as required, the DD Division provides training and education on how to follow the participants plan and assure that plan is followed. If systemic concerns continue, a determination will be made by the DD Division if the provider's license\certification will be affected.

(G-4) If the citation is one of neglect, the provider will provide training and education to the staff and assure that they are properly trained on the implementation of the plan on how to prevent future choking incidents from occurring. If systemic concerns continue or the provider fails to not follow the recommendations they have developed, or the ones P&A may have recommended, a determination will be made by the DD Division if the provider's license\certification will be affected.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The DD Division is investigating options to utilize the web-based application to facilitate more timely reporting and accurate collection of data for adding information to the QER for performance measure G-2, G-3, and for performance measure G-4 determining to have trained all DD providers to put the information into the web based data system correctly. Anticipated date for implementation for performance measures G-2, G-3, and G-4 is March 31, 2015.

Appendix H: Quality Improvement Strategy (1 of 2)

Under 1915(c) of the Social Security Act and 42 CFR 441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DD Division is responsible for evaluating the effectiveness and outcomes of the discovery, remediation, and quality improvement plans. The Division prioritizes its remediation efforts to address any problems that involve client care or health and welfare issues first. The Division keeps track of its quality improvement efforts by maintaining databases and statistics that include applicable time frames for completion. The Division uses this information to make necessary changes to improve quality.

When pre-determined performance measures are not met or problems (that are not directly related to

participant care or health welfare and safety issues) are identified, DD discusses the issue(s) at meetings and develops a plan of action. The action plan is documented and may include, providing information to DDPA's and DDPM's addressing updated policy/protocol as needed. If the problem involves client care or health welfare and safety issues the problem is addressed immediately. Policy is updated as needed.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The DD Division monitors system design changes and discusses at meetings the need for changes. The DD Division maintains a quality assurance plan that describes system improvements and other remediation efforts. The DD Division keeps track of identified problems and tracks the number of errors that are identified over time. If no improvement is seen new strategies are put in place.

Quality improvement strategies are discussed monthly with DD Division staff and at least annually with other stake holders. Other stake holders may include but are not limited to P & A, Health Facilities, DD Provider association, Money Follows the Person Program Director, the Long Term Care Program Administrator, the Mental Health Program Administrator, and the Assistant Medical Services Director.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The DD Division will evaluate the quality improvement strategies once during the waiver period and prior to renewal of the waiver.

The results of the analysis are shared with various stakeholders\entities to determine appropriate revisions, prioritization, and changes in mitigation strategies.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

An allowable cost-based retrospective rate setting system is utilized. Annually, provider's actual costs and revenue are audited by the DHS Provider Audit Unit. In order to be eligible for reimbursement, the provider must participate in the program audit and utilization review process established by the department. Providers under contract with the

department to provide services to individuals with developmental disabilities must submit to the department, no less than annually, a statement of actual costs. Providers must disclose all costs and all revenues. Providers must identify income to offset costs when applicable in order that state financial participation not supplant or duplicate other funding sources. The final rate established per the program audit review process is payment for all allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to eligible clients subject to limitations and cost offsets per North Dakota Administrative Code 75-04-05. The audits include review of reported costs to determine that they are allowable according to the rules. Final rates are then determined by census data, revenue, and allowable costs. The audit is then settled with payback by the provider if payments exceed allowable costs. The process, allowable and non-allowable cost definitions, and accounting requirements are set out in North Dakota Administrative Code Chapter (NDAC) 75-04-05 and Purchase of Service requirements in NDAC 75-04-02.

For self-directed services the Fiscal Agent contractor has developed an on-line balance sheet report that indicates total budget, expenditures and remaining funds. This information is available to families and DDPMs. If families request, a copy of the balance sheet report is mailed to them monthly or as requested. Families may also call the Fiscal Agent for updated information. The authorization process prevents over billing by the fiscal agent as the MMIS has edits that prohibit payments in excess of authorized budget limits. Central office staff monitor monthly budget program spend down reports generated through MMIS and monthly contract billings for fiscal agent services. As outlined in the contract with the North Dakota Department of Human Services, the fiscal agent also has agreed to have an independent audit conducted and will share the results.

The State agency responsible for conducting the state's financial audit is the Office of the State Auditor. An audit of the State of North Dakota Comprehensive Annual Financial Report is conducted annually by the State Auditor's Office. This audit involves examining, on a test basis, evidence supporting the revenues, expenditures and disclosures in the financial statements, assessing the accounting principles used and evaluating the overall financial statement presentation.

An agency audit of the Department of Human Services is performed every two years. This audit is a result of the statutory responsibility of the State Auditor to audit each state agency once every two years and is a report on internal control, on compliance with State and Federal laws, and on efficiency and effectiveness of agency operations.

The State Auditor's Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

DDPMs determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). DDPMs authorize services on the participants plan in the web based data system.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State□s quality improvement strategy, provide information in the following fields to detail the State□s methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

      Performance Measures

      For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
(I-1) Number and percent of Traditional waiver service claims that paid out at the authorized amount. N: Number of Traditional waiver service claims that paid out at the authorized amount. D: Total number of claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Payment System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
(I-2) Number and percent of provider payment rates that is consistent with the rate methodology in the approved waiver or subsequent amendment. N: Number of consistent provider payment rates. D: Total number of payment rates.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Manual Review of final rate determination and final computation of settlement

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State□s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(I-1) Samples are not pulled for review as ALL claims that do not pass edits built into the system are suspended within MMIS. The claims processing unit reviews all suspended claims and advises the provider if the claim is not properly coded. The provider will receive a remittance advise with a code indicating the cause of the suspension. The provider and DDPM work together to correct the billing error.

During the provider audit process, if non-allowable costs are identified in the cost report, the costs are disallowed in the final rate determination.

(I-2) The Provider Audit unit reviews the actual costs and actual units of the DD providers and informs the DD Division by sending the final audit which includes the final rate determination and final computation settlement. The DD Division sends the final audit to the DD provider requesting payment or informing the provider of the additional payment.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Program rates are primarily determined by the collective need (amount of services) of the individuals in the program, salary and fringe costs, and administration (fixed/operating costs). Retrospective rate-setting requires that an interim rate be established prior to the year in which it will be effective. Providers are required to submit a statement of budgeted costs to the department no less than annually so an interim rate may be determined. The determination of a final rate for all services begins with the reported cost of the provider's operations for that fiscal year. Once it has been determined that reported costs are allowable, reasonable, and client-related, those costs are compared to the

reimbursements received through the interim rate. Settlements are made through a recoupment or refund to the department for an overpayment or an additional payment to the provider for an underpayment.

The approved level of DD participation for administrative and general client salaries will be determined from base year audited costs, plus adjustments for legislatively approved inflationary and/or hourly wage increases. The approved level of DD participation for direct service salaries is based on established hourly wage allowances, plus adjustments for legislatively approved inflationary and/or hourly wage increases. The approved level of DD participation for 'other' and property costs will be determined from base year audited costs, plus adjustments for legislatively approved inflationary increases. In order to be eligible for reimbursement, the provider must participate in the program audit and utilization review process established by the department. Providers under contract with the department to provide services to individuals with developmental disabilities must submit to the department, no less than annually, a statement of actual costs. Providers must disclose all costs and all revenues. Providers must identify income to offset costs when applicable in order that state financial participation not supplant or duplicate other funding sources. The final rate established per the program audit review process is payment for all allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to eligible clients subject to limitations and cost offsets per North Dakota Administrative Code 75-04-05.

A number of opportunities are provided for public comment into the rate setting process. The public notification and comment solicitation for rules governing rate setting for the waiver include a variety of stakeholders. Prior to beginning development of proposed budgets-including the waiver-the department held public hearings in all eight regional human service centers to solicit input. In addition, the DD Division participates in the Legislative Partnership Committee, a planning group--represented by the entities listed above plus other interested persons—that develops a legislative priorities agenda which includes rates and rate setting issues. Salary and fringe costs and inflationary adjustments are determined by legislative appropriation and are subject to that public process. Base staffing ratios and allowable costs are stipulated in ND Administrative Code 75-04-05 which is promulgated through a public notice and hearing process as required by state law.

A number of service rates include added factors for absences in the unit rate (Day Habilitation) or provide retainer payments for absent days (30 days maximum per year: Congregate Care, MSLA, TCLF, ISLA, SLA, and FCO III).

ISLA, Parenting Support, In-Home Supports, Family Care Option, Family Care Option III, and Extended Home Health Care rates are developed from an Administrative cost reimbursement, program supervision and management reimbursement based on a difficulty of care schedule, and direct intervention time (direct support staff salary and fringes) as recommended by interdisciplinary teams and reviewed and approved by the Regional DD Program Administrator and the DD Division. ISLA, Family Care Option, and Family Care Option III are paid as daily rates. In-Home Supports, Parenting Supports, Extended Home Health Care and Extended Services are paid at an hourly rate.

The provider is reimbursed for services to a participant on the basis of reasonable and allowable cost per Department of Human Services rules. Reported allowable costs are included in determining the interim and final rate. The method of finalizing the reimbursement rate per unit is through the use of the retrospective rate setting system.

Note: Adjustments for anticipated legislatively approved inflationary increases for all services have been included in the Cost Neutrality Demonstration in Appendix J.

Cost factors in determining interim rates for Residential Habilitation (Congregate Care MSLA, SLA, and TCLF), Extended Services and Day Supports include Administrative expenses, General Client (program supervision and management) Direct Care Staff salary and fringes, other (operating expenses). These expenses are based on allowable costs for each provider for a base year. Adjustments are then made for difficulty of care (as recommended by interdisciplinary teams and approved by the Regional DD Program Administrator and DD Division), approved inflationary increases, and changes in units budgeted.

Infant Development has four established fee for service pay points which include evaluation\ assessment, home visit, consultations, and IFSP development. The dollar amount for these pay points were established by stakeholder and state comparison process. Adjustments are made based on legislatively approved inflationary increases.

Adult Day Health and Homemaker rates are based on appropriation cap per unit of service plus an administrative expense for agency providers. Providers select a rate up to the cap.

Adult Family Foster Care rates are determined according to a rate worksheet completed by the DDPM which assesses actual intervention needs of the individual. The resulting score yields a monthly reimbursement. Relief care may be provided according to intensity of support needs.

Environmental Modifications and Equipment and Supplies rates are determined by the individual within an individualized budget developed with the DDPM and approved by the Regional DDPA and the DD Division.

Behavioral Consultation: The participant and/or legal decision maker, other Team members, and the DDPM discuss and decide when the service is needed and how it will be implemented based upon the annual waiver cap. The amount is reviewed/approved by the Regional DDPA and the DD Division.

Transportation for Financially Responsible Caregivers: The rate is based on prior authorization of mileage and transportation related costs such as lodging and meals. The state reimbursement guidelines regarding transportation reimbursement are followed as they are for Medicaid State Plan transportation reimbursement. These reimbursement rates of lodging and meals were initially established by the Department based on historical, reasonable, and customary costs. They may be inflated due to legislative increases. A transportation grid was developed to assure consistency in determining when the state plan will reimburse transportation and when it can be reimbursed through the waiver.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from the provider of the service to the State's claim payment system for all services except self-directed services. In self-directed services, participants direct bills or invoices to the fiscal agent. The fiscal agent pays the vendor or reimburses the participant, codes the claims as to specific type, and bills through the state claims payment system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DDPMs determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). DDPMs then authorize services on the Individual Service Plan in the web based data system. Edits are not built into the MMIS system to prevent payment for services not authorized. However, the subsequent checks described (numbered 1-7) are in place to assure services are received as billed.

The DD Claims reviewer receives weekly queries of the web based data system for individual changes to Level of Care and start or termination of waivered services. The ICF/IID Level of Care determinations are entered into an MMIS file. The Individual Service Plan information authorizing a waiver service is entered into a DD eligibility file which includes the service authorized, dates for which authorized, provider number and Medicaid number and rate and frequency.

Another file contains provider rates by provider number. Provider's bill for services by client Medicaid number, service code, provider number, dates of service and units of service. Numerous edits assure that claims are paid properly. In order for a claim to be paid for waiver services, the system I) determines the individual is currently eligible for MA, 2) the person has a current level of care screening and code for DD waiver services, 3) the service is currently authorized by DDPMs, 4) the billed rate is correct for that individual, provider, or program, 5) units billed are within authorized amounts, 6) units billed are within maximum allowable, 7) there are no competing claims for the same service and time period.

If any of the above are absent from the system or conflict, the claim will suspend or be denied. The claims reviewer then receives reports of suspended or denied claims and the reason. For individualized rates (ISLA, In-Home Support, Family Care Option, Family Care Option III, and Extended Services) DDPMs complete an individualized authorization document. Through an automated work flow process, this is forwarded to the Regional DDPA for review and approval and then to the DD Division for review and approval. With final DD Division approval it is forwarded to the DD Claims reviewer to enter the authorized amount and dates of service, the rate, and authorized provider.

Additional checks are in place to assure services are received as billed. At least every 90 days the DDPM meets with the individual to complete a Quality Enhancement Review. Included in that review is whether or not the service has been provided and the individual's satisfaction with it. The DDPM also updates the In-Home and self-directed authorizations to reflect actual hours delivered.

Providers are required to maintain census reports by individual to verify that services were provided.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR □92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

(a) Waiver services that may qualify for the difficulty of care payments are for Residential Habilitation, Day Habilitation, Extended Services, provider managed In-Home Supports and Family Care Option III.

(b) The Department enters into a contract with each licensed DD Provider agency that provides services for those participants who qualify for the difficulty of care payment dollar amounts for the identified participants.

(c) Annually, the providers' actual costs and revenue are audited by the DHS Provider Audit Unit. In order for the provider to be eligible for difficulty of care payments the provider must participate in the program audit and utilization review process established by the Department. The provider must identify income to offset when applicable to ensure that State financial participation not supplant or duplicate other funding sources. The difficulty of care payments per the audit review process ensures payments are for allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to the eligible participants subject to limitations and cost offsets per North Dakota Administrative Code 75-04-05. The audits include review of reported costs to determine that they are allowable according to the rules.

(d) Federal fund draws are not requested until the payments have been made to the qualified provider. At the end of each quarter the Department claims the federal funds on the CMS 64 report based off of the payments made to the qualified providers.

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A fiscal agent is used for self-directed service payments. In self-directed services, participants direct bills or invoices to the fiscal agent. The fiscal agent pays the vendor or reimburses the participant, codes the claims as to specific type, and bills through the state claims payment system. On-line accounts are available for participants, the DDPM monitors, individual budgets, and account balances. Quarterly reports of the fiscal agent are available to the DD Division.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Two of the Department of Human Services Regional Human Service Centers and the Life Skills and Transition Center (State operated facility) provides direct services to waiver participants. Rates are based on actual costs. Services provided are Day Supports, Extended Services and ISLA.

A number of county social service boards are providers of Homemaker Services. Rates are set in the same manner as for all agency providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ◉ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching

arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (•) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and board rates are established by providers according to the provisions of NDAC 75-04-05. Those costs are not allowable in costs claimed by the provider for waiver services. The provider collects the room and board costs directly from individuals receiving services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (•) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	34863.97	5317.35	40181.32	119996.30	3905.31	123901.61	83720.29
2	38452.43	5530.05	43982.48	124796.15	4061.52	128857.67	84875.19
3	41353.57	5751.25	47104.82	129787.99	4223.98	134011.97	86907.15
4	44101.20	5981.30	50082.50	134979.51	4392.94	139372.45	89289.95
5	47462.26	6220.55	53682.81	140378.69	4568.66	144947.35	91264.54

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care: ICF/IID
Year 1	5260	5260
Year 2	5365	5365
Year 3	5470	5470
Year 4	5575	5575
Year 5	5680	5680

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Data from the most recent 372 that was submitted to CMS on 09/30/2013 was used to calculate and combined and the estimate for average length of stay is 310.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The number of users estimated for waiver year (WY) 1 is based off of a combination of various data sources including state fiscal year (SFY) 2013 spend downs, CMS 372 reports for WY1, WY2, and WY 3, and the 13/15 biennium budget. The SFY 2013 spend downs and the CMS 372 reports for WY1, WY2, and WY3 are reports that show the actual current expenditures and utilization for waiver services. The 13/15 biennium budget was developed based off of actual expenditures and utilization from the 11/13 biennium and increased for legislatively approved increases. The increase in the utilization was determined by average increases over the current WY1 through WY5.

Average costs per unit consists of:
Costs per unit for WY1 for Day Habilitation, Extended Services, Congregate Care, MSLA, TCLF, and SLA are based off of the average interim rate for SFY 2013 inflated by 3% for legislatively approved increases. For WY2 through WY5 the rate is increased by 4% inflation based on historic Legislative rate increases.

Costs per unit for WY1 for In-Home Supports; Infant Development – Evaluation/Assessment, IFSP, Home Visit, and Consultation; and Parenting Supports uses SFY 2013 Budget Instruction rates and inflated by 3% for legislatively approved increases. For WY2 through WY5 the rate is increased by 4% inflation based on historic Legislative rate increases.

Costs per unit for WY1 for FCO III, ISLA, and Extended Home Health Care uses SFY 2013 authorizations and inflated by 3% for legislatively approved increases. For WY2 through WY5 the rate is increased by 4% inflation based on historic Legislative rate increases.

Costs per unit for WY1 for Self-Directed Supports – Behavioral Consult, Environmental Modification, Equipment and Supplies, and Transportation uses WY3 – 372 report increased by Legislative Inflationary increases of 3% for WY4, 3% for WY5, and 3% for new WY1. For WY2 through WY5 the rate is increased by 4% inflation based on historic Legislative rate increases.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is determined by using the 372 Annual Report on HCBS waiver expenditures submitted to CMS on 09/30/13 showing expenditures for 04/01/11 to 03/31/12 an inflationary increase of 3% for the year 2013 and 3% additional increase for the waiver year (WY) WY1. For WY2 through WY5 the rate is increased by 4% inflation based on historic Legislative rate increases.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

A state generated report is used to calculate the G factor. The G factor is based on the current average Medicaid costs for hospital, NF, or ICF/IID services for those individuals eligible for the HCBS waiver minus the average ICF/IID recipient liability, this amount is inflated by 3% for the year 2012 and an additional increase for the waiver year 2013 due to legislation intent. The amount is inflated by 3% for WY1

and 4% WY2-WY5 which is based on historical inflationary rate increases given to ICF's/IID through the legislative process.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

A state generated report is used to calculate the G' factor. The G' factor is the average cost of other Medicaid services that are not included in Factor G. This amount is inflated by 4% for WY1-WY5 based on historical inflationary rate increases given to ICF's/IID through the Legislative process.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	C
Adult Day Health	
Day Supports	
Extended Services	
Homemaker	
Residential Habilitation	
Extended Home Health Care	
Adult Family Foster Care	
Behavioral Consultation	
Environmental Modifications	
Equipment and Supplies	
Family Care Option	
In-Home Supports	
Infant Development	
Parenting Support	
Transportation Costs for Financially Responsible Caregiver	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**10058.28**
Adult Day Health					**10058.28**	
				GRAND TOTAL:		**183384475.03**
				Total Estimated Unduplicated Participants:		**5260**
				Factor D (Divide total by number of participants):		**34863.97**
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1/2 day	2	158.00	31.83		
Day Supports Total:						**52111836.00**
Day Supports	hour	1295	1840.00	21.87	**52111836.00**	
Extended Services Total:						**3732960.00**
Extended Services	hour	330	320.00	35.35	**3732960.00**	
Homemaker Total:						**35321.00**
Homemaker	15 minute	11	650.00	4.94	**35321.00**	
Residential Habilitation Total:						**96671257.20**
Transitional Community Living Facility	day	159	360.00	216.05	**12366702.00**	
Individualized Supported Living Arrangement	day	884	360.00	180.62	**57480508.80**	
Supported Living Arrangement	day	120	360.00	14.38	**621216.00**	
Minimally Supervised Living Arrangements	day	245	360.00	235.14	**20739348.00**	
Family Care Option III	day	24	360.00	333.71	**2883254.40**	
Congregate Care	day	42	360.00	170.65	**2580228.00**	
Extended Home Health Care Total:						**1182675.40**
Extended Home Health Care	hour	10	2251.00	52.54	**1182675.40**	
Adult Family Foster Care Total:						**681462.00**
Adult Family Foster Care	day	30	340.00	66.81	**681462.00**	
Behavioral Consultation Total:						**255268.26**
Behavioral Consultation	hour	54	13.00	363.63	**255268.26**	
Environmental Modifications Total:						**155848.00**
Environmental Modifications	item	44	4.00	885.50	**155848.00**	
Equipment and Supplies Total:						**584059.68**
Equipment and Supplies	item	383	3.20	476.55	**584059.68**	
Family Care Option Total:						

GRAND TOTAL:	**183384475.03**
Total Estimated Unduplicated Participants:	**5260**
Factor D (Divide total by number of participants):	**34863.97**
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						345844.80
Family Care Option	day	14	282.00	87.60	345844.80	
In-Home Supports Total:						15265848.94
In-Home Supports	hour	794	569.00	33.79	15265848.94	
Infant Development Total:						11432821.81
IFSP/IFSP Review	IFSP	2176	3.00	448.05	2924870.40	
Evaluations/Assessments	evaluations	2783	1.00	462.47	1287054.01	
Consultations	consultations	1786	4.00	281.19	2008821.36	
Home Visits	Home Visits	1073	36.00	134.93	5212076.04	
Parenting Support Total:						87313.36
Parenting Support	hour	17	152.00	33.79	87313.36	
Transportation Costs for Financially Responsible Caregiver Total:						831900.30
Out of State	trip	231	5.00	487.99	563628.45	
In State	trip	231	5.00	232.27	268271.85	
				GRAND TOTAL:		183384475.03
				Total Estimated Unduplicated Participants:		5260
				Factor D (Divide total by number of participants):		34863.97
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						10592.00
				GRAND TOTAL:		206297303.57
				Total Estimated Unduplicated Participants:		5365
				Factor D (Divide total by number of participants):		38452.43
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health	1/2 day	2	160.00	33.10	10592.00	
Day Supports Total:						59038497.60
Day Supports	hour	1411	1840.00	22.74	59038497.60	
Extended Services Total:						4070067.20
Extended Services	hour	346	320.00	36.76	4070067.20	
Homemaker Total:						40092.00
Homemaker	15 minute	12	650.00	5.14	40092.00	
Residential Habilitation Total:						108369136.80
Transitional Community Living Facility	day	163	360.00	224.69	13184809.20	
Individualized Supported Living Arrangement	day	975	360.00	187.84	65931840.00	
Supported Living Arrangement	day	129	360.00	14.96	694742.40	
Minimally Supervised Living Arrangements	day	257	360.00	244.55	22625766.00	
Family Care Option III	day	26	360.00	347.06	3248481.60	
Congregate Care	day	42	360.00	177.48	2683497.60	
Extended Home Health Care Total:						1352941.04
Extended Home Health Care	hour	11	2251.00	54.64	1352941.04	
Adult Family Foster Care Total:						755942.40
Adult Family Foster Care	day	32	340.00	69.48	755942.40	
Behavioral Consultation Total:						309729.42
Behavioral Consultation	hour	63	13.00	378.18	309729.42	
Environmental Modifications Total:						191551.36
Environmental Modifications	item	52	4.00	920.92	191551.36	
Equipment and Supplies Total:						656584.13
Equipment and Supplies	item	414	3.20	495.61	656584.13	
Family Care Option Total:						

GRAND TOTAL:	206297303.57
Total Estimated Unduplicated Participants:	5365
Factor D (Divide total by number of participants):	38452.43
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						411043.20
Family Care Option	day	16	282.00	91.10	411043.20	
In-Home Supports Total:						17425926.00
In-Home Supports	hour	855	580.00	35.14	17425926.00	
Infant Development Total:						12666428.03
IFSP/IFSP Review	IFSP	2273	3.00	465.97	3177449.43	
Evaluations/Assessments	day	2924	1.00	480.97	1406356.28	
Consultations	consultations	1874	4.00	292.44	2192130.24	
Home Visits	Home Visits	1166	36.00	140.33	5890492.08	
Parenting Support Total:						96143.04
Parenting Support	1 hour	18	152.00	35.14	96143.04	
Transportation Costs for Financially Responsible Caregiver Total:						902629.35
Out of State	trip	241	5.00	507.51	611549.55	
In State	trip	241	5.00	241.56	291079.80	
				GRAND TOTAL:		206297303.57
				Total Estimated Unduplicated Participants:		5365
				Factor D (Divide total by number of participants):		38452.43
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						11152.08
				GRAND TOTAL:		226204036.84
				Total Estimated Unduplicated Participants:		5470
				Factor D (Divide total by number of participants):		41353.57
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health	1/2 day	2	162.00	34.42	11152.08	
Day Supports Total:						64403680.00
Day Supports	hour	1480	1840.00	23.65	64403680.00	
Extended Services Total:						4428563.20
Extended Services	hour	362	320.00	38.23	4428563.20	
Homemaker Total:						45207.50
Homemaker	15 minute	13	650.00	5.35	45207.50	
Residential Habilitation Total:						118294851.60
Transitional Community Living Facility	day	167	360.00	233.68	14048841.60	
Individualized Supported Living Arrangement	day	1031	360.00	195.35	72506106.00	
Supported Living Arrangement	day	138	360.00	15.56	773020.80	
Minimally Supervised Living Arrangements	day	268	360.00	254.33	24537758.40	
Family Care Option III	day	28	360.00	360.94	3638275.20	
Congregate Care	day	42	360.00	184.58	2790849.60	
Extended Home Health Care Total:						1535091.96
Extended Home Health Care	hour	12	2251.00	56.83	1535091.96	
Adult Family Foster Care Total:						835325.60
Adult Family Foster Care	day	34	340.00	72.26	835325.60	
Behavioral Consultation Total:						368138.16
Behavioral Consultation	hour	72	13.00	393.31	368138.16	
Environmental Modifications Total:						229862.40
Environmental Modifications	item	60	4.00	957.76	229862.40	
Equipment and Supplies Total:						733972.32
Equipment and Supplies	item	445	3.20	515.43	733972.32	
Family Care Option Total:						

GRAND TOTAL:	226204036.84
Total Estimated Unduplicated Participants:	5470
Factor D (Divide total by number of participants):	41353.57
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						480900.24
Family Care Option	day	18	282.00	94.74	480900.24	
In-Home Supports Total:						20153779.65
In-Home Supports	hour	933	591.00	36.55	20153779.65	
Infant Development Total:						13600273.08
IFSP/IFSP Review	IFSP/IFSP Review	2325	3.00	484.61	3380154.75	
Evaluations/Assessments	Evaluations/Assessm	3045	1.00	500.21	1523139.45	
Consultations	Consultations	1919	4.00	304.14	2334578.64	
Home Visits	Home Visits	1211	36.00	145.94	6362400.24	
Parenting Support Total:						105556.40
Parenting Support	1 hour	19	152.00	36.55	105556.40	
Transportation Costs for Financially Responsible Caregiver Total:						977682.65
Out of State	trip	251	5.00	527.81	662401.55	
In State	trip	251	5.00	251.22	315281.10	
				GRAND TOTAL:		226204036.84
				Total Estimated Unduplicated Participants:		5470
				Factor D (Divide total by number of participants):		41353.57
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						11742.40
				GRAND TOTAL:		245864179.44
				Total Estimated Unduplicated Participants:		5575
				Factor D (Divide total by number of participants):		44101.20
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health	1/2 day	2	164.00	35.80	11742.40	
Day Supports Total:						70249728.00
Day Supports	hour	1552	1840.00	24.60	70249728.00	
Extended Services Total:						4809369.60
Extended Services	hour	378	320.00	39.76	4809369.60	
Homemaker Total:						50596.00
Homemaker	15 minute	14	650.00	5.56	50596.00	
Residential Habilitation Total:						127998874.80
Transitional Community Living Facility	day	171	360.00	243.03	14960926.80	
Individualized Supported Living Arrangement	day	1082	360.00	203.16	79134883.20	
Supported Living Arrangement	day	147	360.00	16.18	856245.60	
Minimally Supervised Living Arrangements	day	274	360.00	264.50	26090280.00	
Family Care Option III	day	30	360.00	375.38	4054104.00	
Congregate Care	day	42	360.00	191.96	2902435.20	
Extended Home Health Care Total:						1729443.30
Extended Home Health Care	hour	13	2251.00	59.10	1729443.30	
Adult Family Foster Care Total:						919836.00
Adult Family Foster Care	day	36	340.00	75.15	919836.00	
Behavioral Consultation Total:						430719.12
Behavioral Consultation	hour	81	13.00	409.04	430719.12	
Environmental Modifications Total:						270931.04
Environmental Modifications	item	68	4.00	996.07	270931.04	
Equipment and Supplies Total:						816511.36
Equipment and Supplies	item	476	3.20	536.05	816511.36	
Family Care Option Total:						

GRAND TOTAL:	245864179.44
Total Estimated Unduplicated Participants:	5575
Factor D (Divide total by number of participants):	44101.20
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						555709.20
Family Care Option	day	20	282.00	98.53	555709.20	
In-Home Supports Total:						22218441.42
In-Home Supports	hour	971	602.00	38.01	22218441.42	
Infant Development Total:						14629428.85
IFSP/IFSP Review	IFSP/IFSP Review	2397	3.00	503.99	3624192.09	
Evaluations/Assessments	Evaluations/Assesm	3186	1.00	520.22	1657420.92	
Consultations	Consultations	1964	4.00	316.31	2484931.36	
Home Visits	Home Visits	1256	36.00	151.78	6862884.48	
Parenting Support Total:						115550.40
Parenting Support	1 hour	20	152.00	38.01	115550.40	
Transportation Costs for Financially Responsible Caregiver Total:						1057297.95
Out of State	trip	261	5.00	548.92	716340.60	
In State	trip	261	5.00	261.27	340957.35	
				GRAND TOTAL:		245864179.44
				Total Estimated Unduplicated Participants:		5575
				Factor D (Divide total by number of participants):		44101.20
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						12360.36
				GRAND TOTAL:		269585641.29
				Total Estimated Unduplicated Participants:		5680
				Factor D (Divide total by number of participants):		47462.26
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health	1/2 day	2	166.00	37.23	12360.36	
Day Supports Total:						79637702.40
Day Supports	hour	1692	1840.00	25.58	79637702.40	
Extended Services Total:						5213408.00
Extended Services	hour	394	320.00	41.35	5213408.00	
Homemaker Total:						56355.00
Homemaker	15 minute	15	650.00	5.78	56355.00	
Residential Habilitation Total:						137929456.80
Transitional Community Living Facility	day	171	360.00	252.75	15559290.00	
Individualized Supported Living Arrangement	day	1133	360.00	211.29	86180965.20	
Supported Living Arrangement	day	156	360.00	16.83	945172.80	
Minimally Supervised Living Arrangements	day	280	360.00	275.08	27728064.00	
Family Care Option III	day	32	360.00	390.40	4497408.00	
Congregate Care	day	42	360.00	199.64	3018556.80	
Extended Home Health Care Total:						1936850.44
Extended Home Health Care	hour	14	2251.00	61.46	1936850.44	
Adult Family Foster Care Total:						1009827.20
Adult Family Foster Care	day	38	340.00	78.16	1009827.20	
Behavioral Consultation Total:						497718.00
Behavioral Consultation	hour	90	13.00	425.40	497718.00	
Environmental Modifications Total:						314916.64
Environmental Modifications	item	76	4.00	1035.91	314916.64	
Equipment and Supplies Total:						904471.78
Equipment and Supplies	item	507	3.20	557.49	904471.78	
Family Care Option Total:						

GRAND TOTAL:	269585641.29
Total Estimated Unduplicated Participants:	5680
Factor D (Divide total by number of participants):	47462.26
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						635723.88
Family Care Option	day	22	282.00	102.47	**635723.88**	
In-Home Supports Total:						**24449977.01**
In-Home Supports	hour	1009	613.00	39.53	**24449977.01**	
Infant Development Total:						**15718971.02**
IFSP/IFSP Review	IFSP/IFSP Review	2469	3.00	524.15	**3882379.05**	
Evaluations/Assessments	Evaluations/Assessm	3327	1.00	541.03	**1800006.81**	
Consultations	Consultations	2009	4.00	328.96	**2643522.56**	
Home Visits	Home Visits	1301	36.00	157.85	**7393062.60**	
Parenting Support Total:						**126179.76**
Parenting Support	1 hour	21	152.00	39.53	**126179.76**	
Transportation Costs for Financially Responsible Caregiver Total:						**1141723.00**
Out of State	trip	271	5.00	570.88	**773542.40**	
In State	trip	271	5.00	271.72	**368180.60**	

GRAND TOTAL:	**269585641.29**
Total Estimated Unduplicated Participants:	**5680**
Factor D (Divide total by number of participants):	**47462.26**
Average Length of Stay on the Waiver:	310