# 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 waivers 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

## 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

In Appendix B – slots were increased by 150 each year of the waiver and update performance measure B-2.
In Appendix C- modifications and clarification was made in Day Habilitation, Homemaker, Independent Habilitation, Individual Employment Support, Extended Home Health Care, Environmental Modifications, Equipment and Supplies, and In-Home Supports. Community Transition Services was added as a new service. Performance measures C-1 and C-4 were updated and C-3 was removed.
In Appendix D- performance measures D-3, D-4, and the remediation was updated.
In Appendix E- updated the goal for number of participants each year of the waiver and removed co-employer as an option for participant employer status.
In Appendix F- added State Grievance/Complaint System
In Appendix G- updated safeguards concerning the use of restrictive interventions, updated performance measure G-1 and the remediation for performance measures.

# 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: renewal**

**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**
**Waiver Number:ND.0037.R08.00**
**Draft ID: ND.007.08.00**

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

Regular Waiver

**E. Proposed Effective Date:** (mm/dd/yy)

04/01/19

**Approved Effective Date: 04/01/19**

## 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 or individuals with related conditions (as defined in 42 CFR §435.1009) and cognitive impairment who meet the ICF/IID level of care (as defined in 42 CFR §440.150(a)(2)). Cognitive impairment means that a person performs significantly below appropriate age level in brain function (perception, attention, memory, motor, language, executive functioning), and the impairments are not severe enough to qualify as an intellectual disability.

## 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 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. The services are to provide support for conditions specifically related to IID/DD. 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:

Prior to beginning development of proposed waiver, the department held public hearings in all eight regional human service centers to solicit input. Public hearings were held on 5/29/18, 5/30/18, 5/31/18, 6/1/18, and 6/4/18.

On 10/17/18 the Medicaid Advisory Committee was informed of the upcoming public comment period during the Medicaid Advisory Committee meeting.

As required by waiver criteria and the North Dakota Medicaid State Plan, a letter was sent to all Tribal Chairman, Tribal Health Directors and Indian Health Service Representatives in North Dakota on 10/31/18. The letter notified them of the Departments intent to submit a waiver renewal, provided a description of the anticipated changes, and explained the process to provide input. The waiver renewal was available on the Department's website and copies were available upon request. The tribal consultation notification letter was also posted on the Department's website.

In addition to the Tribal notification, a public notice was issued on 10/30/18 to seek public comment on the waiver renewal. The public notice contained a link to the proposed waiver renewal, identified the time frame for public comment, methods to submit public comment, and a Power Point presentation highlighting the proposed changes. Written public comments were accepted through November 29, 2018. The public notice can be viewed at: http://www.nd.gov/dhs/info/publicnotice/2018/10-30-public-comment-period-iid-dd-traditional-hcbs-waiver-2019.pdf The power point can be viewed at: http://www.nd.gov/dhs/services/disabilities/docs/slides-proposed-changes-to-draft-iid-dd-hcbs-waiver-renewal-2019.pdf

On 10/31/18 a press release was also issued. The press release contained a link to the proposed waiver renewal, identified the time frame for public comment, methods to submit public comment, and a Power Point presentation highlighting the proposed changes. This press release can be viewed at: http://www.nd.gov/dhs/info/news/2018/10-31-dhs-seeks-comment-developmental-disabilities-waiver.pdf

On 11/13/18, at the Tribal Consultation meeting the participants were informed of the current public comment period.

The Department received a total of 18 comments on the proposed waiver renewal during the public comment period. The following is a summary of the public comments received and the Department's response to the comments.

Eligibility: Commenters expressed concern that the current waiver eligibility criteria is associated with a cognitive disability and urged the Department to consider changing the criteria to allow children with physical disabilities without intellectual disabilities. Commenters indicated that children with physical disabilities incur additional medical expenses and not having access to the waiver creates an added burden to the families.

State's response: The Traditional ID/DD waiver's target group (as provided in 42 CFR §441.301(b)(1)(iii)(C) is composed of individuals who otherwise would require the level of care furnished in an ICF/IID, which is defined in 42 CFR §440.150(a)(2) as serving persons with "intellectual disability or persons with related conditions." The ICF/IID level of care is reserved for persons with intellectual disability or a related condition, as defined in 42 CFR §435.1009. Participants in a waiver linked to the ICF/IID level of care must meet the "related condition" definition when they are not diagnosed as having an intellectual disability (e.g., persons with autism). Some persons who might qualify as having a "developmental disability" under the Federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 may not meet ICF/IID level of care. While "Developmental Disability" and "Related Conditions" overlap, they are not equivalent. Additionally, some of the services that the commenters identified as beneficial are not available under the wavier but reimbursable under the Medicaid State Plan. Families do not need to be eligible for the wavier to apply for Medicaid.

Capacity: Commenter expressed appreciation for increasing the capacity.

State's response: Thank you for the positive comment.

Transportation Reimbursement: Commenters expressed it would be beneficial to receive reimbursement for travel expenses associated with medical appointments.

State's response: Medical transportation expenses are reimbursable under the North Dakota Medicaid State Plan and adding this service to the waiver would be a duplication.

Equipment and Supplies: Commenters expressed concerns that the change to the financial limit ($4,000 annually vs $20,000 for 5-year waiver period) would not allow for home modifications, vehicle modifications, home tracking systems, lifts, etc. An additional commenter expressed concern with not covering generic devices. Two commenters expressed appreciation for the addition of a personal tracking system, personal monitoring system, and special medical supplies. Commenter shared concern with removing the coverage for assistive technology and therapy.

State's response: The items the commenters identified are typically allowable under the service of Environmental Modifications. The Department is not proposing any change to the limits of that service. If an item under equipment and supplies is necessary to prevent institutionalization the Department may make an exception to the annual limit of $4000. The Department did consider allowing generic devices but concluded these devices are not specific to a participant's disability. Reimbursement for disability specific apps are allowable under this service.The Department is not proposing any changes to the coverage of assistive technology, as the item removed was coordination and can be incorporated into the definition of the service.

(This public input section continues into the Additional Needed Information Section before the Tribal information of that section.)

**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:** Heidi

**First Name:** Zander

**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) 328-8945 **Ext:** ☐ **TTY**

**Fax:**

(701) 328-8969

**E-mail:**

hzander@nd.gov

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **North Dakota**

**Zip:**

**Phone:**

**Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:** Heidi Zander

State Medicaid Director or Designee

**Submission Date:** Mar 19, 2019

**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:** Medical Serivces Director

**Agency:** ND Department of Human Services

**Address:** 600 East Boulevard Ave Dept 325

**Address 2:**

**City:** Bismarck

**State:** **North Dakota**

**Zip:** 58501

**Phone:** (701) 328-1603 **Ext:** ☐ **TTY**

**Fax:** (701) 328-1544

**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.*

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the State’s most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continue from I. Public Input:
Day Habilitation: Commenter stated it is nice to see the 8 hour/day limit in Day Habilitation removed.

State's response: Thank you for the positive comment.

Miscellaneous: Commenter requested consideration to allow family members to receive income to stay at home and care for their medical fragile child.

State's response: The Department appreciates the comment. A change of this nature would have an impact on the appropriations and would need approval from the Legislation.

Miscellaneous: Commenter suggested thoughtfulness with the name change of "special home." And requested if it could just be the DD Wavier or HCBS Waiver, without calling it special.

State's Response: The Department is not proposing a name change to the waiver. The renewal identifies the title as The Traditional IID/DD Home and Community Based Waiver. It's believed the language the commenter is referring to is template language.

Tribal Information:
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, Tina Bay, DD Director, 1237 West Divide Avenue, Suite 1A, Bismarck, ND 58501-1208, (701) 328-8966, tbay@nd.gov

*(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 DD Division is responsible for the assessment of performance of the fiscal agent and this is monitored through regular calls or contacts with the fiscal agent, regional staff, and families.

## 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). Feedback from DDPMs and families working with the Fiscal Agent will be used to measure satisfaction.

The Fiscal Agent contract is monitored at least every six months following the Department of Human Services contract oversight procedures. Monitoring includes calls with DD Division Staff, monthly reports to the regional administrators and ongoing telephone contact with families and DDPMs.

## 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** | ☒ | ☐ |
| **Utilization management** | ☒ | ☐ |

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| **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 States quality improvement strategy, provide information in the following fields to detail the States 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):* |
|---|---|---|
| ☐ **State Medicaid** | ☐ **Weekly** | ☒ **100% Review** |

| Agency | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>Fiscal Agent | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

**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 States 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 management system by DDPM. DDPM communicates resolution to Fiscal Agent.

**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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(as defined in 42 CFR §435.1009) and cognitive impairment who meet the ICF/IID level of care (as defined in 42 CFR §440.150(a)(2)). Cognitive impairment means that a person performs significantly below appropriate age level in brain function (perception, attention, memory, motor, language, executive functioning), and the impairments are not severe enough to qualify as an intellectual disability.

**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** | 5830 |
| **Year 2** | 5980 |
| **Year 3** | 6130 |
| **Year 4** | 6280 |
| **Year 5** | 6430 |

**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 |
|---|
| **Infant Development** |
| **Transition from Supported Employment to Individual Employment Support services** |
| **Emergency** |

## 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):*

Infant Development

**Purpose** *(describe):*

The State will reserve slots for children birth through two years of age to provide intervention in a timely manner for young children who will benefit from infant development services. The primary caregiver chooses which option best meets their family's needs.

**Describe how the amount of reserved capacity was determined:**

Based on current enrollment in the program and past utilization.

**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 (2 of 4)

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

Transition from Supported Employment to Individual Employment Support 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 Individual Employment Support 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:**

Based on current enrollment in the program and past utilization.

**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 |
| 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):*

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/or an individual who is in need of transitioning from a State institution and their needs can also be met in a home and community based service situation; and whose needs can be addressed through licensed DD waiver services.

Reserved slots are managed through the DD Division.

**Describe how the amount of reserved capacity was determined:**

Based on current enrollment in the program and past utilization.

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

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 50 |

| Waiver Year | Capacity Reserved |
|---|---|
| Year 2 | 50 |
| Year 3 | 50 |
| Year 4 | 50 |
| Year 5 | 50 |

## 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:

"Common slots" are slots, minus the reserved slot capacity. Common slots are available to eligible participants on a first-come, first-served basis. Reserved slots are assigned, based on the categories defined in the waiver. When the waiver cap, including both common and reserved slots is reached, a waiting list will be maintained based on the date of request of service. If the reserved capacity for 'Emergency' has been exhausted, applicants whose situation meets the definition for 'Emergency' will be given priority when slots become available.

As long as common slots are available, participants have access to all wavier services that are based on their need. Once the common slots have been utilized, reserved slots are available (infant development, Individual Employment, Emergency). Applicants wishing to access the waiver at this point will need to meet one of those three categories and the regular eligibility criteria for the waiver. If applicant does not meet the reserved slot criteria, they will be placed on a wait list until common slots are available.

## 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.**

## 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)**
- ☒ **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)**
- ☒ **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 435.110, 435.116 and 435.118; section 1925 Transitional Medical Assistance, 1902(a)(C)(ii)(I), 42 CFR 435.308 and 435.310; 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 spend down 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: 500 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-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 (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 the selections in B-5-c also apply to B-5-f.**

## 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 the selections in B-5-d also apply to B-5-g.**

## 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-intermittent services only

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. When a partipant is only receiving an intermittent service, such as Environmental Modification, the service may not be delivered during a particular month. The DDPM will monitor the use of services as part of the quality 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 a government agency 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 an intellectual disability 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 or individuals with related conditions as defined in 42 CFR 435.1009 with accompanying cognitive impairment, 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 utilize relevant assessments such as psychological, medical, educational and other 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 management 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 at the annual team meeting that a new assessment will be beneficial or is needed. The results are entered into the web based management 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 management 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 States quality improvement strategy, provide information in the following fields to detail the States 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 participants who had an initial LOC indicating need for ICF/IID LOC prior to receipt of services. N: Number of new waiver participants who had a LOC prior to receiving services. D: All new waiver participants.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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 = |
| ☐ **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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 the required initial level of care determination accurately completed by a qualified evaluator. N: Waiver participants who have the required initial level of care determination accurately completed by a qualified evaluator. D: All new waiver participants reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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**<br>Confidence Interval =<br>95% confidence interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 require a corrective action. The DD Division follows up, to ensure the corrective action 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 States 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 case file reviews or 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.

(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 require a corrective action. The DD Division follows up, to ensure corrective action 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 a minimum of 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** | **Day Habilitation** | | |
| **Statutory Service** | **Homemaker** | | |
| **Statutory Service** | **Independent Habilitation** | | |
| **Statutory Service** | **Individual Employment Support** | | |
| **Statutory Service** | **Prevocational Services** | | |
| **Statutory Service** | **Residential Habilitation** | | |
| **Extended State Plan Service** | **Extended Home Health Care** | | |
| **Other Service** | **Adult Foster Care** | | |
| **Other Service** | **Behavioral Consultation** | | |
| **Other Service** | **Community Transition Services** | | |
| **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** | | |

| Service Type | Service | | |
|---|---|---|---|
| Other Service | Small Group Employment Support | | |

## 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):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04020 day habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Day Habilitation services are scheduled activities, formalized training, and staff supports typically provided in a non-residential setting to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities should focus on improving a participant's sensorimotor, cognitive, communication and social interaction skills. The goal of this service is to enable the participant to attain or maintain his or her maximum physical, intellectual, emotional and social functional level. Day Habilitation services should facilitate and foster community participation as indicated in each participant's person-centered service plan.

Services are designed to maximize the functioning of persons with developmental disabilities and shall be coordinated with any needed therapies in the participant's person-centered service plan, such as physical, occupational, or speech therapy.

This service shall be provided in a non-residential setting, separate from the participant's private residence or other residential living arrangement. However, this service may be furnished in a residence if the participant's needs are documented in the participant's person-centered service plan.

This service is to provide support for conditions specifically related to IID/DD.

Rates for Day Habilitation may include transportation costs to access program related activities in the community. Transportation does not include travel between the participant's home and the Day Habilitation site. Any transportation provided to an participant 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:**

This service will not be authorized, nor payment made, for participants who are eligible for services under the Individuals with Disabilities Education Act.

This service cannot duplicate any other service in this waiver.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, or Homemaker services.

This service shall be available to those receiving Individual Employment Support, Small Group Employment Support and Prevocational Services subject to limitations stipulated in the Division policy. Billing for such services may not be duplicated in a time period (e.g., billed for more than one service for 1:00 p.m. to 5:00 p.m. on April 1). Hours in Day Habilitation, Individual Employment Support, Small Group Employment Support, and Prevocational Services may not exceed 40 cumulative hours per week per participant.

Day Habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purposes of producing goods or performing services).

Day Habilitation cannot be authorized on the individual service plan with Family Care Option.

**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 | Licensed DD Provider |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Day Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Licensed DD Provider

**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:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 08 Home-Based Services | 08050 homemaker |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

The purpose of homemaker services is to complete environmental tasks that a participant with a disability is not able to complete in order to maintain that participant'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 and requests this service, the assessment must identify why the capable person or provider cannot perform the task. Prior approval from the DD Division is required.

This service is to provide support for conditions specifically related to IID/DD.

**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 can not be authorized. Transportation or escorting the participant 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 a participant living with an individual that is able to perform the homemaking tasks. Homemaker services cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, Family Care Option or Adult Foster Care.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, Behavioral Consultation, Parenting Support, Extended Home Health Care, In-Home Supports, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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 | 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:**

Habilitation

**Alternate Service Title (if any):**

Independent Habilitation

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Independent Habilitation is formalized training and staff supports provided for fewer than 24 hours per day based upon the participants needs. Independent Habilitation is typically not delivered on a daily basis. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Independent Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

Eligible participants must not be living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The participant may be living with other individuals who may or may not be receiving waiver services.

This service is to provide support for conditions specifically related to IID/DD.

Multiple participants living in a single or a shared private residence are eligible for this service.

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

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

This service cannot duplicate any other service in this waiver.

The service cannot be authorized on the individual service plan with In-Home Supports, Residential Habilitation, Adult Foster Care, Homemaker, Family Care Option, Parenting Support, Adult Foster Care, or Medicaid State Plan Services.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, Extended Home Health Care, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.

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

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

**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 |
|---|---|
| Individual | Licensed DD Provider |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Independent Habilitation**

**Provider Category:**

Individual

**Provider Type:**

Licensed DD Provider

**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:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

Individual Employment Support

**HCBS Taxonomy:**

| Category | Sub-Category |
|---|---|
| **Category 1:** 03 Supported Employment | **Sub-Category 1:** 03021 ongoing supported employment, individual |
| **Category 2:** | **Sub-Category 2:** |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Individual Employment Support services are long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting or self-employment. This service is designed for participants who need intensive ongoing support to perform in a work setting. Service includes on- or off-the-job employment-related support for participants needing intervention to assist them in obtaining or maintaining employment, in accordance with their person-centered service plan. Supports are provided on an individual basis. Participants are paid by the employer at or above minimum wage.

Transportation costs from a participant's residence to their workplace may be included in the service rate when a participant needs it as a support intervention for the participant 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 under any other service in this waiver or Medicaid State Plan. If transportation is to be included in the rate, the Regional DDPA must certify the number of participants for whom transportation is necessary as part of intervention to successfully support continued employment.

This service is to provide support for conditions specifically related to IID/DD.

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

Direct intervention time for this service shall only be provided to one participant at a time.

This service cannot duplicate any other service in this waiver.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, or Homemaker services.

This service shall be available to those receiving Day Habilitation, Prevocational Services, and Small Group Employment Support services are subject to limitations stipulated in Division policy. Billing for such services may not be duplicated in a time period (e.g., billed for more than one service for 1:00 to 5:00 p.m. on April 1). Hours in Day Habilitation, Individual Employment Support, Prevocational Services, and Small Group Employment Support services may not exceed 40 cumulative hours per week per participant.

This service does not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

This service does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

This service does not include training and services available to a participant through the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA).

Individual Employment cannot be authorized on the individual service plan with Family Care Option.

**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 |
|---|---|
| Individual | Licensed DD Provider |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Individual Employment Support**

**Provider Category:**

Individual

**Provider Type:**

Licensed DD Provider

**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:**

Statutory Service

**Service:**

Prevocational Services

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 04 Day Services | 04010 prevocational services |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Prevocational Services are formalized training, experiences, and staff supports designed to prepare participants for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services may include training in effective communication within a work setting, workplace conduct and attire, following directions, attending to tasks, problem solving, and workplace safety. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the participant's person-centered service plan.

Rates for Prevocational Services may include transportation costs to access program related activities in the community. Transportation does not include travel between the participant's home and the Prevocational Services program site. Any transportation provided to a participant 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 or Medicaid State Plan.

This service is to provide support for conditions specifically related to IID/DD.

A participant's need and desire for continued Prevocational Services shall be evaluated every twelve (12) months, or more frequently if requested by the participant and/or legal decision maker.

Providers must, in consultation with each participant, develop employment goals/outcomes in their person-centered service plan that outlines a pathway for transitioning to integrated, employment. The person-centered service plans must be updated annually and document each participant's progress toward completion of prevocational training.

The Department will review annually the active progress made during the prior year on increasing work skills, time on tasks, or other job preparedness objectives. The Developmental Disabilities Program Administrator (DDPA) may approve an additional 12 months, twice (for a total of 24 months), of prevocational training with submission of employment outcomes that are consistent with the participant's goals/outcomes in their person-centered service plan. A participant who requests to remain in the service beyond the two additional approvals from the DDPA (36 months) must receive approval from the DD Division.

Individuals participating in this service may be compensated in accordance with applicable federal laws and regulations.

Participation in this service is not a required prerequisite for Individual Employment or Small Group Employment Support services furnished under this waiver.

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

This service does not include training and services available to a participant through the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act (IDEA).

This service cannot duplicate any other service in this waiver.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, or Homemaker services.

This service shall be available to those receiving Day Habilitation, Individual Employment Support and Small Group Employment Support and subject to limitations stipulated in DD Division policy. Billing for such services may not be duplicated in a time period (e.g., billed for more than one service for 1:00 to 5:00 p.m. on April 1). Hours in Day Habilitation, Individual Employment Support, Small Group Employment and Prevocational Services may not exceed 40 cumulative hours per week per participant.

Prevocational Services cannot be authorized on the individual service plan with Family Care Option.

**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 |
|---|---|
| Individual | Licensed DD Provider |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Prevocational Services**

**Provider Category:**

Individual

**Provider Type:**

Licensed DD Provider

**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:**

Statutory Service

**Service:**

Residential Habilitation

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 02 Round-the-Clock Services | 02011 group living, residential habilitation |
| **Category 2:** | **Sub-Category 2:** |
| 02 Round-the-Clock Services | 02031 in-home residential habilitation |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

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

Eligible participants must not be living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The participant may be living with other individuals who may or may not be receiving waiver services.

This service shall be used to assist with self-care and/or transfer a skill from the direct care staff to the participant.

This service is to provide support for conditions specifically related to IID/DD.

The state, within no more than 1 year, will submit to CMS an amendment to this waiver that revises the temporary absence factor in a manner that comports with CMS requirements.

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

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Independent Habilitation, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.

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

This service cannot duplicate any other service in this waiver.

This service cannot be authorized on the individual service plan with In-Home Supports, Independent Habilitation, Adult Foster Care, Homemaker, Parenting Support, Extended Home Health Care, Family Care Option, or Medicaid State Plan Personal Care services.

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

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

**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 | Licensed DD Provider |

## 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:**

Licensed DD Provider

**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:**

Extended State Plan Service

**Service Title:**

Extended Home Health Care

**HCBS Taxonomy:**

| Category | Sub-Category |
|---|---|
| **Category 1:** 05 Nursing | **Sub-Category 1:** 05010 private duty nursing |
| **Category 2:** 05 Nursing | **Sub-Category 2:** 05020 skilled nursing |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

This service provides skilled nursing tasks to eligible participants who have maximized the amount of service available under the Medicaid State Plan. A nurse assessment and care plan are required. The participant's person-centered service plan must address medical necessity.

This service is available only to participants living with a primary caregiver. Primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.

This service is to provide support for conditions specifically related to IID/DD.

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

This service is not available for individuals who are eligible for services under EPSDT.

This service cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, Family Care Option, Homemaker, and Adult Foster Care.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Parenting Support, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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: 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 licensed according to NDAC 75-04-01.

**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 Foster Care

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 02 Round-the-Clock Services | 02023 shared living, other |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

**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 Foster Care provider that lives in the home. Adult Foster Care (AFC) is provided to adults who receive these services while residing in a licensed AFC home.

Non-medical transportation is a component of AFC and is included in the rate.

This service is to provide support for conditions specifically related to IID/DD.

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

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

AFC cannot be authorized on the individual service plan with Residential Habilitation, Independent Habilitation, In-Home Supports, Family Care Option, Homemaker Services, Parenting Support, Equipment and Supplies, Environmental Modifications, Extended Home Health Care, Behavioral Consultation or with Medicaid State Plan Personal Care services.

Room and board costs are not included in the AFC payment.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. AFC 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 service options. The DDPM makes participants aware of the service cap.

The total number of individuals who live in the AFC home who are unrelated to the AFC provider cannot exceed four (4).

Limits may be increased as determined by legislative action.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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 |
|---|---|
| Individual | Licensed AFC provider |

## Appendix C: Participant Services

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

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

**Provider Category:**

Individual

**Provider Type:**

Licensed AFC 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 AFC home is valid for 1 year. AFC 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: |
| --- | --- |
| 10 Other Mental Health and Behavioral Services | 10040 behavior support |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**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. 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 behavioral consultant with input from the participant’s team and incorporated into the participant’s person-centered service plan.

This service is to provide support for conditions specifically related to IID/DD.

**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 or training of staff.

Behavioral Consultation excludes services provided through the IEP.

Behavioral Consultation is limited to $5,200 per participant per State Fiscal Year unless an exception is approved by the DHS/DDD to prevent imminent institutionalization. Given that this is a self-directed service the participant\legal decision maker must choose a service provider who meets Department set parameters of the provider's specifications of the service. The participant\legal decision maker chooses the appropriate provider dependent on the participant's budget and the provider rates.

To avoid duplication of services, behavioral consultation is not available to participant's who receive Residential Habilitation or Independent Rehabilitation as behavioral consultation is included as a professional service.

Behavioral Consultation services cannot be provided in the Family Care Option setting or foster care setting, but may be authorized in the natural family home when the participant is present and the requirements above are met.

Behavioral Consultation services cannot be authorized on the individual service plan with Adult Foster Care services or Infant Development.

This service may not be provided in a clinical setting or a school.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Extended Home Health Care, Parenting Support, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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 |
|---|---|
| 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 employed, not contracted, by a licensed DD Provider.

**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:**

Community Transition Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 16 Community Transition Services | 16010 community transition services |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Community Transition Services is a one-time cost for non-recurring set-up expenses for participants who are transitioning from an institution to a home and community-based setting where the participant wishes to reside. Allowable community transition services are those where the participant is directly responsible for their living expenses and includes:
•essential household furnishings and moving expense required to occupy and use within their home; including furniture, window coverings, food preparation items and bed/bath linens;
•set-up fees or deposits for utility or service access, including telephone, electricity, heating, water, and security deposits.

Items purchased via this service are the property of the participant.

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

Community Transition Services do not include expenses that constitute room and board; monthly rental or mortgage expense; escrow; specials; insurance; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may be utilized for qualifying expenses up to 180 consecutive days prior to admission to the waiver and 90 days after the date the participant became eligible for the waiver. One-time transition costs are limited up to $3000 per eligible participant per waiver period.

Community Transition Services are subject to prior authorization and funds are furnished only to the extent that they are necessary as identified in the service plan. The state utilizes a transitional budget form that details an inventory of expenses deemed necessary to move from an institution and establish a home in the community. The funds are only available if the individual is unable to meet such expenses or when the services are not able to be obtained from other sources.

The participant must be reasonably expected to be eligible for and to enroll in the waiver.

This service is limited to participants coming from a ND Medicaid Institutional setting who have resided there for a minimum of 60 consecutive days.

This service cannot duplicate any other service in this waiver.

This service is limited to participants who are moving into a setting with 6 or fewer people.

**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 | Licensed DD Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Community Transition Services**

**Provider Category:**

Agency

**Provider Type:**

Licensed DD Provider

**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:**

Environmental Modifications

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**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. A primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization. The 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 participant'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) any modifications must be done primarily for the participant with the 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 as related to letters a through e below:
a) Roll in shower
b) Sink modifications
c) Bathtub modifications
d) Toilet modifications
e) Water faucet controls
(4) Improve access/ease of mobility, excluding locks, as related to letters a through c below:
a) Widening of doorways/hallways,
b) turnaround space modifications,
c)floor coverings
(5) Specialized accessibility/safety adaptations/additions as related to letters a through f below:
a) Electrical wiring
b) Fire safety adaptations
c) Shatterproof windows
d) Modifications to meet egress regulations if there are no other egress options available in the structure
e) Automatic door openers/doorbells
f) Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant.
(6)Modifications and/or additions to kitchen facilities as related to letters a through c below:
a)Sink modifications
b)Water faucet controls
c)Counter/Cupboard modifications

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 primary caregiver must own 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. 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

This service is to provide support for conditions specifically related to IID/DD.

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

The amount of service for environmental modifications will not exceed $20,000 per participant for the duration of the waiver period. The authorization database will track the amount authorized and utilized to prevent over-expenditure. If the request for home modifications (environmental modifications) is anticipated to exceed $500, it is required to have three estimates to determine the most cost-efficient material for the adaptation to meet the participant's needs. All other requests are reviewed by the Department on a case by case basis to determine if the request is reasonable and appropriate.

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.

Home 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.

Home modifications are 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).

Home modifications will not be approved for new construction (building a new house) or unfinished area (i.e. basement).

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

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 participant, 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 home modifications that have 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 purchasing a vehicle with adaptations; service and maintenance contracts and extended warranties are not covered. Adaptations for a vehicle purchased, rented, or leased 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 vehicles that are owned or leased by paid providers of waiver services.

This service cannot duplicate any other service in this waiver.

**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 |
| Individual | Individual |

## 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 provides 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:**

Participant or primary caregiver

**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:**

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 the participant or legal decision maker as cost effective.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Participant or primary caregiver

**Frequency of Verification:**

Prior to modifications

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: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PERS) |
| **Category 2:** | **Sub-Category 2:** |
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
| **Category 3:** | **Sub-Category 3:** |
| 14 Equipment, Technology, and Modifications | 14032 supplies |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**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. The participant's needs identified through the person centered planning process in the following areas can be addressed through the participants budget process.

Participant and/or legal decision maker along with the team members will identify the appropriate equipment and supplies within the participants plan.

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. switches, grab devices);

(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 including 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.

e) 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) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

5) 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;

(f) Personal Monitoring System is an electronic device or control that enables waiver participants to secure help in an emergency, be monitored to maintain health safety, or promote independence without paid staff. The response center is staffed by trained professionals. Installation, upkeep, and maintenance of devices/systems are provided;

(g) Personal Tracking System is a device or control for the waiver participant that enables them to be located or monitored when there is a health and safety risk related to the participant’s disability. Installation, upkeep, and maintenance of devices/systems are provided; and

(h) Specialized Medical supplies gloves, diapers, wipes, hospital bed, and nutritional supplements.

This service is to provide support for conditions specifically related to IID/DD.

**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.

The Department limits this service to $4,000 per participant per waiver year unless an exception is approved by the DHS/DD to prevent imminent institutionalization . 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 devices and items (e.g. tablets, computers, printers, ancillary items, exercise equipment, cell phones, home security systems) are not allowed.

Nutritional supplements are only covered when they constitute 51% or more of nutritional intake to ensure that it is not duplicated under the Medicaid State Plan.

This service cannot duplicate any other service in this waiver.

**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 | 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):*

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:**

Fiscal Agent

**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: |
|---|---|
| 02 Round-the-Clock Services | 02021 shared living, residential habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Family Care Option is provided out of the participant's home, in another family home meeting the safety standards for Family or Adult 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 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, and show preference. This service also helps to 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.

This service is to provide support for conditions specifically related to IID/DD.

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

Family Care Option is not provided in group residential settings.

Participants receiving services in Family Care Option must have an active IEP (Individual Education Plan).

Family Care Option cannot be authorized on the individual service plan with Adult Foster Care, Residential Habilitation or Independent Habilitation service.

IHS, Homemaker, and EHHC cannot be provided in the Family Care Option setting but may be authorized in the natural family home when the participant is present, and the requirements are met.

This service is not available to participants under the custody of county social services.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, Parenting Support, Behavioral Consultation, Day Habilitation, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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: 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:** |
|---|---|
| 05 Nursing | 05010 private duty nursing |
| **Category 2:** | **Sub-Category 2:** |
| 05 Nursing | 05020 skilled nursing |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

This service requires the need for a specially trained caregiver 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 their primary caregiver in preventing or delaying unwanted out of home placement. A primary caregiver is a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.

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 caregiver is either away from the home or is home, but unavailable to care for the participant. The team determines the appropriate tasks or activities that are provided during the primary caregiver's presence or absence and this is included in the participant's person-centered service plan.

This service is to provide support for conditions specifically related to IID/DD.

**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.

The participants receiving In Home Supports (IHS) are supported in the home in which they live or in the home of the support staff, if the home is approved by the legal decision maker.

IHS may not be provided in a group or a facility-based setting.

IHS is not authorized when Part B services of IDEA are offered through the North Dakota Department of Public Instruction as indicated in the participants active IEP.

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

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 if the total number of hours and staff can be combined to still ensure each participant's health and safety.

IHS payments will not be authorized 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 authorized on the individual service plan with Residential Habilitation, Independent Habilitation, or Adult Foster Care.

IHS may not be provided at the same time as Day Habilitation and Medicaid State Plan Personal Care services.

In-Home Support cannot be provided in a Family Care Option setting but may be authorized in the natural family home when the participant is present and the requirements above are met.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, Extended Home Health Care, Parenting Support, Behavioral Consultation, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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 | Licensed DD Provider |
| 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:**

Licensed DD Provider
**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: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |
| 09 Caregiver Support | 09020 caregiver counseling and/or training |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**

- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

**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.

This service is to provide support for conditions specifically related to IID/DD.

**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 through 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.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant. These services include Medicaid State Plan Services, In-Home Supports, Self-Directed Services, Family Care Option, or Extended Home Health Care.

To avoid duplication, Infant Development cannot be authorized on the individual service plan with Behavioral Consultation, Residential Habilitation, Independent Habilitation, Parenting Support, Adult Foster Care, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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 | Licensed DD Provider |

## 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:**

Licensed DD Provider

**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: |
|---|---|
| 13 Participant Training | 13010 participant training |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Category 4:** **Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Parenting Support assists participants who are, or will be, parents. Parenting Support is different from family support programs as the eligible participant is the parent. In other family support programs the eligible participant 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.

This service is to provide support for conditions specifically related to IID/DD.

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

Parenting 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 cannot be authorized on the individual service plan with Residential Habilitation or Independent Habilitation. 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.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Family Care Option, Extended Home Health Care, Adult Foster Care, Behavioral Consultation, Day Habilitation, Homemaker services, Prevocational Services, Small Group Employment Supports, or Individual Employment.

This service cannot duplicate any other service in this waiver.

**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: Other Service**
**Service Name: Parenting Support**

**Provider Category:**

Agency

**Provider Type:**

Licensed DD Provider

**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:**

Small Group Employment Support

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
| --- | --- |
| 03 Supported Employment | 03022 ongoing supported employment, group |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one* **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

**Service Definition** *(Scope):*

Small Group Employment Support services provide long-term ongoing supports to assist participants in maintaining paid employment in an integrated setting. Services include on- or off-the-job employment-related support for small groups of participants needing intervention to assist them in obtaining and maintaining employment as a group, in accordance with their person-centered service plan. Supports are provided to groups of two (2) to eight (8) employed participants. Participants are paid by the employer for work performed in accordance with State and Federal laws.

Transportation costs from a participant's residence to their workplace may be included in the service rate when a participant needs it as a support intervention for the participant 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 under any other service in this waiver or Medicaid State Plan. If transportation is to be included in the rate, the Regional DDPA must certify the number of participants for whom transportation is necessary as part of intervention to successfully support continued employment.

This service is to provide support for conditions specifically related to IID/DD.

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

Group size shall be limited to no fewer than two (2) and no more than eight (8) participants.

This service cannot duplicate any other service in this waiver.

This service may not be used to support a self-employed participant.

This service shall not be furnished or billed at the same time of day as other services that provide direct care to the participant.These services include Medicaid State Plan Services, In-Home Supports, Residential Habilitation, Independent Habilitation, Extended Home Health Care, Parenting Support, Adult Foster Care, Behavioral Consultation, or Homemaker services.

This service shall be available to those receiving Day Habilitation, Prevocational Services and Individual Employment Support Services are subject to limitations stipulated in Division policy. Billing for such services may not be duplicated in a time period (e.g., billed for more than one service for 1:00 to 5:00 p.m. on April 1). Hours in Day Habilitation, Individual Employment Support, Prevocational Services, and Small Group Employment Support Services may not exceed 40 cumulative hours per week per participant.

This service does not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

This service does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

This service does not include training and services available to a participant through the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act (IDEA).

Supported Employment cannot be authorized on the individual service plan with Family Care Option.

**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 |
|---|---|
| Individual | Licensed DD Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Small Group Employment Support**

**Provider Category:**

Individual

**Provider Type:**

Licensed DD Provider

**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: 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.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *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.

Per DD policy the Division reviews applicable records of an applicant to determine if the individual is eligible to be considered for employment by a licensed DD provider according to NDAC. If the offense is a direct bearing offense, the DD provider is notified that the employee cannot provide services to the DD participant..

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.

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 | |
|---|---|
| **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 more than three beds allow participants to live in residential neighborhoods in the community. Meals may be 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.

Per NDAC, residential group homes are located in residential areas and provide full access to typical facilities in a home such as a kitchen with cooking facilities, dining areas, access to privacy, participants have the freedom to furnish and decorate their living areas according to their personal tastes and interests, easy access to visitors at times convenient to the participant, participants have the freedom and support to control their own schedules and activities, and have access to food at any time.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Residential Group Homes

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Behavioral Consultation** | ☐ |
| **Independent Habilitation** | ☐ |
| **Equipment and Supplies** | ☐ |
| **Day Habilitation** | ☐ |
| **Extended Home Health Care** | ☐ |
| **Community Transition Services** | ☐ |
| **Environmental Modifications** | ☐ |
| **Prevocational Services** | ☐ |
| **Infant Development** | ☐ |
| **Small Group Employment Support** | ☐ |
| **Adult Foster Care** | ☐ |
| **Homemaker** | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Individual Employment Support** | ☐ |
| **In-Home Supports** | ☐ |
| **Family Care Option** | ☐ |
| **Parenting Support** | ☐ |
| **Residential Habilitation** | ☒ |

**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 | ☒ |
| 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.*

  [ ] **Self-directed**

  [ ] **Agency-operated**

**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.

  The following services may be provided by a relative for payment; Homemaker, SD-IHS, Environmental Modification, Equipment and Supplies, Family Care Option. No payments may be made to a legal guardian.

  Authorizations are created based on team decisions regarding services that are in the best interest of the individual. Medicaid payment system requires an appropriate level of care screening for the waiver, pre-authorize on the individual service plan, and current individual service authorization in order for payment to be made within specified timelines and limits.

- ( ) **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 States quality improvement strategy, provide information in the following fields to detail the States 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, who meet licensure requirements initially and continually. N: Number of providers, who met licensure requirements initially and continually. D: All licensed providers.**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

**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 self-directed services(SDS)that have met ND State requirements. N: All self-directed services that have met ND State requirements. D: All self-directed services.**

**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: |

| | | |
|---|---|---|
| | | |
| | ☒ **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: |

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 full-time DD licensed provider staff who have successfully completed State required module training. N: Number of full-time DD licensed provider staff who have successfully completed State required module training. D: All full-time DD licensed provider staff.**

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

| **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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Semi Annually |

**Performance Measure:**
**(C-4) Number and percent of personnel administering medications through a licensed DD provider who completed the medication training requirements N: Number of personnel administering medications through a licensed DD provider who completed the medication training requirements D: Number of personnel administering medications through a licensed DD provider.**

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

| **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**<br>Confidence Interval = |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☐ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>100% of medication certified staff at selected providers will be reviewed annually. |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>Semi Annually |

**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 States 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.

(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) Training contractor sends out a list of full-time DD licensed provider staff that has not completed their training as required and the provider must provide information on how this is going to be remediated.

**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**<br>Specify: | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 settings for the services listed below are presumed to fully comply with the regulatory requirements because they are settings where individualized services are being 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.

Services with Fully Compliant HCB Waiver Settings:
- 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
- Prevocational services
- Individual Employment Support
- Small Group Employment Support
- Independent Habilitation

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 current protocol refers to the separate titles for various 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)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
*Specify qualifications:*

The Qualified Developmental Disabilities Professional (QDDP) 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:*

☒ **Other**
*Specify the individuals and their qualifications:*

The service plan is developed at a team meeting. Team members include the participant, legal decision maker, DDPM, service provider and other members.

For Residential Habilitation, Independent Habilitation, Prevocational Services, Individual Employment Support, Small Group Employment Support, Day Habilitation, In-Home Support, Family Care Option and Parenting Support services staff of DD licensed providers of waiver services acts in a clerical manner and enters the plan into the web based application as it was developed during the team meeting. The staff must meet the qualifications of QDDP.

For self-directed services (Behavior Consult, In-Home Support, Environmental Modification, and Equipment & Supplies), AFC, Extended Home Health Care, and Homemaker the DDPM enters the service plan into the web based application as it was developed during the team meeting.

Primary Early Intervention Professionals (PEIP)within the Infant Development provider acts in a clerical manner to enter the Individual Family Service Plan as it was developed during the team meeting. PEIPs are licensed in their profession such as early childhood special education, occupational therapy, physical therapy, speech language pathology, social work and nursing.

## 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:*

## 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 when a participant and/or legal decision maker signs the ISP. The rights are included in this 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):

The plan is developed at the team meeting by the team, including the participant, legal decision maker, DDPM, provider, and other members. The provider, whom acts in a clerical manner, enters the plan into the web based application as it was developed during the team meeting. As the representative for the State Medicaid Agency, the DDPM is responsible to review the plan to ensure that the plan has been developed in accordance with applicable policies and procedures. Only plans that meet the requirements will be approved. Approved plans cannot be edited. If any change is to be made a new plan must be created and the DDPM must approve the revisions.

(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 and their chosen team members in developing the plan.

In addition to the participant, 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 participant providing direct support and care, and know the participant best are encouraged to participate and will be invited to participate if the participant/legal decision maker agrees.

When there is conflict between the participant or legal guardian, family members, or other members of the team, the issues should be addressed immediately in a neutral and respectful manner utilizing conflict management strategies. The DDPM has the ultimate responsibility to ensure concerns related to authorized services or implementations of the person-centered service plan are addressed in collaboration with the QDDP of the provider agency and team. The participant or legal guardian can contact an advocate to assist, if they desire. Documentation of the decisions and discussions is reviewed with all parties before it is finalized and implemented.

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. If any changes are to be made, a new service plan must be created by the team and the DDPM must approve the new plan revisions. The planning process takes into account cultural considerations of the participant by providing information in a language that is understandable to the participant with no professional jargon and accessible to those who are limited English proficient.

(b) Assessments:

A variety of assessments are completed to support the person-centered 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 which are then incorporated in the participant's plan. Risk Assessment: This assessment assists the individual and the team in identifying significant risks to the participant's health and safety. Health Assessment: This assessment summarizes the participant's medical, mental health, daily living skills, etc. as appropriate for the team's review.

(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, self-directed services, 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 service plan lists the waiver services that are authorized for the participant which includes the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service. It also lists generic services and natural supports the participant receives. This section can only be edited and completed by the DDPM. This section is locked and the service provider has no ability to perform clerical functions to this section. 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.

The service plan is finalized and agreed to, with the informed consent of the participant and/or legal decision maker. The services plan is signed by all participants and providers responsible for its implementation. The participant and/or legal decision maker shall receive a copy of the plan and others as determined by the participant.

(g) How and when the plan is updated/changes to the plan

The service plan is updated at least annually or more often if there is a change in the participant’s needs.If any changes are made, a new service plan must be created by the team and the DDPM must approve the new plan revisions.

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 DDPM's face to face visit with the participant and\or contact with the legal decision maker. The face to face visit with the participant and\or 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 review or an update of 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.

Through the risk assessment, potential risks are identified, including but not limited to risks related to financial concerns, legal issues, fire safety, falls, access to health care, family issues, informal/community/social supports, mental health / behavioral health needs, cognitive decision making, nutrition, medication, employment, education, and housing.

The participant's plan lists potential risks, interventions and supports used. The plan is based on the participant's assessed need and must address rights restrictions, any behavioral support interventions, and must document the due process. Evaluation of less intrusive methods and any other approaches that have been taken to mitigate those risks must be included and submitted to the Behavior Management Committee and/or Human Rights Committee for approval. The document must include an assurance that the intervention should not cause harm to the participant. The plan includes documentation of a periodic review of these risks and mitigation strategies to determine if they are still necessary to assure health and safety. Participants are fully informed of the plan and any modifications made to their preferences or goals to assure safety.

The emergency 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 interviews of potential providers and touring program sites selected by the participant. The person-centered service plan will include documentation of the alternative settings that were considered 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.

The DDPM is responsible to review the service plan to ensure that the service plan has been developed as discussed in the team meeting and in accordance with applicable policies and procedures. Only service plans that meet the requirements will be approved. Approved service plans cannot be edited by the service provider. If any change is to be made a new service plan must be created by the team and the DDPM must approve the new service plan revisions.

The service plan lists the waiver services that are authorized for the participant which includes the amount, type, frequency, name of service provider, service funding source, and start/end dates of the service. It also lists generic services and natural supports the participant receives. This section can only be edited and completed by the DDPM. This section is locked and the service provider has no ability to perform clerical functions to this section. This is completed and the service plan approved by the DDPM before payment can be made to the service provider.

A sample of the service plans are reviewed by the State DD Division through a variety of quality monitoring methods.

## 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 plan identifies the DDPM who 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 will monitor that services are furnished in accordance with the service plan, services meet the participant's needs, emergency back up plans are effective, participants exercise their choice of provider, and have 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, the participant's satisfaction with services, addresses any concerns, and ensures no unnecessary or inappropriate services are being provided.

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 participant 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 any other documents 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 six (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 through a variety of quality monitoring methods.

**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 States quality improvement strategy, provide information in the following fields to detail the States 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 address assessed health and safety needs identified through the assessment process. N: Number of participant plans that that address assessed health and safety needs identified through the assessment process. D: Total number of plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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**<br>Confidence Interval =<br>95% Confidence Interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(D-2) Number and percent of participant plans that address assessed personal goals identified through the assessment process. N: Number of participant plans that address assessed personal goals identified through the assessment process. D: Total number of plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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**<br>Confidence Interval =<br>95% Confidence Interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>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 participants 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-3) Number and percent of the participant plans are updated at least annually or when the participant's needs change. N: Number of participant plans updated annually or when a participant's needs change. D: Total number of plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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**<br>Confidence Interval =<br>95% Confidence Interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>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-4) Number and percent of participants who receive the services in accordance with their plan including type, scope, amount, duration and frequency. N: Number of participants and/or legal decision makers who report they did receive the services in their plan including type, scope, amount, duration, and frequency. D: Total number of plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% Confidence Interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**(D-5) The number and percent of participant ISPs delivered as specified, including**

**the type, scope, amount, duration and frequency. N: The total number of participant ISPs delivered as specified. D: The total number of participant ISPs reviewed**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:
**DD licensed provider, 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**<br>Confidence Interval =<br>95% Confidence Interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**e.** ***Sub-assurance: Participants are afforded choice: 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-6) 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: Total number of ISPs reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file 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** | ☐ **Weekly** | ☐ **100% Review** |

| | | |
|---|---|---|
| **Agency** | | |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% Confidence Interval, +/-5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Other**<br>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 States 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 and may require a corrective action. Follow up is completed per DD Division policy.

(D1) The DDPA/DD Division reviews the assessments, in the sample, and ensures that all identified health and safety needs and personal goals are addressed in the plan. The DDPA addresses the corrective action with the respective DDPM. If a participant's plan needs to be updated, a team meeting is held as specified by the DD Division policy. The DD Division verifies that corrections are made.

(D2) The DDPA/DD Division reviews the plan, in the sample, to ensure plans are updated annually and as needs change. The DDPA addresses the corrective action with the respective DDPM. If a participant's plan needs to be updated, a team meeting is held as specified by the DD Division policy. The DD Division 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 DDPA addresses the corrective action with the respective DDPM. If a participant's plan needs to be updated, a team meeting is held as specified by the DD Division policy. The DD Division verifies that corrections are made.

(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 case file review, signed ISP is reviewed for completion. The DDPA addresses the corrective action with the respective DDPM. The DD Division verifies that corrections are made.

**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** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 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 Behavioral Consultation, Environmental Modifications, and Equipment and Supplies. These services are, solely, participant-directed. In-Home Supports 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 |
|---|---|---|
| **Behavioral Consultation** | ☐ | ☒ |
| **Equipment and Supplies** | ☐ | ☒ |

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Environmental Modifications | ☐ | ☒ |
| In-Home Supports | ☒ | ☒ |

## 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:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **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:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **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**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **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 six months) 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 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 |
|---|---|
| **Behavioral Consultation** | ☐ |
| **Independent Habilitation** | ☐ |
| **Equipment and Supplies** | ☐ |
| **Day Habilitation** | ☐ |
| **Extended Home Health Care** | ☐ |
| **Community Transition Services** | ☐ |
| **Environmental Modifications** | ☐ |
| **Prevocational Services** | ☐ |
| **Infant Development** | ☐ |
| **Small Group Employment Support** | ☐ |
| **Adult Foster Care** | ☐ |
| **Homemaker** | ☐ |
| **Individual Employment Support** | ☐ |
| **In-Home Supports** | ☐ |
| **Family Care Option** | ☐ |
| **Parenting Support** | ☐ |
| **Residential Habilitation** | ☐ |

☒ **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 and assist them with locating sources of waiver goods and services.

The DD Division conducts case file 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 noted on 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 participant's 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 waiver services 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** | | 320 |
| **Year 2** | | 330 |
| **Year 3** | | 340 |
| **Year 4** | | 350 |
| **Year 5** | | 360 |

## 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:

☒ **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*:

- [x] **Recruit staff**
- [ ] **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.**

  Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

  The method to conduct background checks does not very from Appendix C-2-a.

- [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)**
- [ ] **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**

- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **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 In-Home Support 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 and DDPM in identifying the participant's needs.

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.

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.

Information is available on the Department's website that the DDPM and Fiscal Agent may direct 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 service 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 of 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 of managing the budget 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 with the DDPM as needed and minimally at the quarterly review.

## 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 their right to a fair hearing.

The service plan that is signed by the participant and/or legal decision maker states: they have 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 service plan identifies that the State approved assessment is required to be eligible to receive specific services. Service hours are determined by the State approved assessment.

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 within 10 calendar days of the date of the written notice, 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 over payment subject to recovery.

Services which utilize an authorization include the notice of the right to appeal adverse actions regarding reduction, denial, or termination of services. Authorizations are completed initially and, at a minimum, annually thereafter with each waiver participant and/or legal decision maker by the DDPM. DDPMs mail the authorization to participants and/or legal decision maker and are available to assist them 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 option 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 an informal option will not preclude or delay the individual's right to a fair hearing.

The request for an informal option must be submitted to the Department within 10 calendar days after the written notice of the determination. Within five working days after the informal option, the Department will issue a written decision.

The DDPM provides assistance to the participant and/or legal decision maker 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:

The Department operates a grievance and complaint systems that afford waiver participants the opportunity to identify and seek the resolution of problems for the services they have been authorized to receive.

**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).

The types of grievances/complaints that participant may register may include but is not limited to issues with provider staff, provider performance, and service delivery. At any time, anyone can register a grievance/complaint to the Department by telephone, mail, in person, email, or fax. Within ten (10) business days, the Department will review and determine the mechanisms that are needed to resolve the grievances/complaints and other entities who may need to be involved to assist in resolution. Mechanisms may include contact with other entities, investigation, on-site visits, licensure status change, and state improvement and monitoring plan. Entities may include Protection and Advocacy, Child Protection Services, the provider accreditation entity, the provider agency, and Regional Human Services Centers. The roles and responsibilities of other entities may include, but is not limited to, information exchange, remediation, plan revision, service change, etc.

Operation of this system does not preclude the participant from requesting a fair hearing to address problems that fall under the scope of the fair hearing process.

## 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. Definitions for child abuse and neglect for individuals under the age of 18 and the role of Child Protective Services are contained in North Dakota Century Code. 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 (defined as critical events per CMS) are reported to, and assessed by an independent third party and are defined in DD Policy. 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, and abuse or neglect is suspected, Child Protective Services (CPS) also receives the report. P & A consults with CPS to determine who will investigate, if an investigation is warranted.

When the event is a participant death, the service provider provides verbal notification to the Protection and Advocacy Project (P & A) and the Regional DD Program Administrator. The State DD Division is notified within one working day of the death once the General Event Report (GER) has been approved. A written report must be submitted within seven working days to P&A, Child Protective Services (if appropriate for children only) Regional DD Program Administrator, and the State DD office. Verbal notification is completed by the provider and then documented in the written GER.

All incidents that do not meet the criteria for a serious event are reviewed by the DD 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 verbally report the incident to P&A. The Regional DD Program Administrator and the State DD Division are notified verbally or in writing within one working day. Notification is completed by the provider and then documented in the written GER. 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 to report the alleged abuse or neglect of a child to Children and Family Services and a general event report (GER) in the web based management system to notify 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 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 may conduct an investigation within five working days of being informed that it doesn't require an independent investigation. The DD Provider will 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 may include 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 findings completed by the service provider. The Department 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 throughout the individual's Quality Enhancement Review (QER) Period, which provides an in-depth monitoring to verify that the recommendations and plan to prevent reoccurrence were implemented. Comments and follow-up are documented in the QER progress notes, which are completed at least every six months for waiver participants. The DDPM discusses the incident and findings with the participant and/or legal decision maker to address any additional areas of concern during the 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 may begin an assessment. This process is all defined in CPS policies.

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 biennially 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 victim 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 according to North Dakota Century Code. CPS would notify law enforcement if the report is criminal in nature. 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 all plans that contain any restrictive or emergency procedures to the 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 any restrictive measures. 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 Management Committee and a Human Rights Committee for review and approval prior to implementation. All staff must be trained prior to implementation, but should not implement the behavior plan until after the approval has been made.

Additionally, the participant’s plan lists potential risks, interventions and supports used. The plan is based on the participant’s assessed need and must address rights restrictions, any behavioral support interventions, and must document the due process. Evaluation of less intrusive methods and any other approaches that have been taken to mitigate those risks must be included and submitted to the Behavior Management Committee and/or Human Rights Committee for approval. The document must include an assurance that the intervention should not cause harm to the participant. The plan includes documentation of a periodic review of these risks and mitigation strategies to determine if they are still necessary to assure health and safety. Participants are fully informed of the plan and any modifications made to their preferences or goals to assure safety.

There are prohibited restraints in the State of ND and are defined in DD Division policy, this includes the use of seclusion.

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. Any of these types of restraints must be included in the plan, approved by the team, and taken through the appropriate committees for approval.

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, Century Code, 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 North Dakota Administrative Code, 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) period to assure the safeguards and requirements are met. The approval of the individual/legal decision maker, Behavior Management Committee and the Human Rights Committee is documented in the person-centered plan.

The use of all unauthorized restraints (those not written into the individual's plan, nor 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 of the verbal report. The Protection and Advocacy Project will be responsible for independent review and to determine if follow up is needed and who is responsible.

The DD Division reviews a random sample of individual records and incident reports biennially 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 techniques may only be utilized as a last resort and must be reported as a serious event per DD Division Policy. Seclusion is prohibited per DD Division Policy.

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(s) 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 at least on a semi-annual 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 nor 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 may be investigated per DD Division policy.

Unauthorized use of restrictive interventions are required to be reported as a serious event per 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 North Dakota Century Code, 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:

The established safeguards and requirements are reviewed by the team including the DDPM, who is an employee of the Department, 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 reviews the use of individual restrictive interventions during the Quality Enhancement Review (QER) period 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 in the person-centered service plan.

The use of all restrictive interventions (those not written into the individual's plan, nor 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 of the verbal report. The Protection and Advocacy Project will be responsible for independent review to determine if follow up is needed and who is responsible.

The DD Division reviews a random sample of individual records and incident reports biennially 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 (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 Regional DD Program Administrator, the participant's DD Program Manager, 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 biennially 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. If the random review reveals restraints that were not authorized or reported, the DD provider is informed of the error and asked to notify the appropriate parties. Any similar situations that were not captured in the random review will need to be reported by the DD Provider. If it is a repeat occurrence, the provider’s monitoring may be elevated to provide a more in-depth review of GERs for the participant and for the provider.

○ **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. For all licensed providers serving non-self-medicating persons they must have written procedures for maintaining, retrieving, and controlling access to medication.

All providers are required to be accredited by CQL. As part of the monitoring of CQL's basic assurance requirements, CQL reviews the providers systems and policies that address psychotropic medications as a chemical restraint. Providers are required to have procedures in place to ensure that participants are free from unnecessary and intrusive intervention which include due process through a behavior intervention committee.

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 personnel administering medications through DD licensed provider,complete the medication training requirements of the ND staff training system and that medication administration is delegated by a licensed medical professional. Periodic review of those personnel is conducted by the designated person at the agency (i.e. nurse) 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. All DD providers are required to enter medication errors in the web-based incident management system at a "medium" notification level, unless it meets an RDG, which is elevated to a "high" notification level. DD Division staff has the ability to review all such reports and a database is maintained which can identify trends in medication administration error reports. The Department reviews all high level GERs, which may include those medication errors that met criteria in the Reporting Determination Guidelines (RDGs).

Individuals living in the home of a legal decision maker/primary caregiver: 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 practicum 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 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 complete the medication training 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 web based management 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 that providers must report are:

- Wrong time
- Wrong person
- Wrong route
- Wrong medication
- Wrong dose
- Wrong documentation

All errors are entered in the web-based management system and recorded at a “medium” level GER, unless it meets the reporting determination guidelines. These are assessed by a third party for a determination of investigation or follow-up. These are considered a “high” level GER. See DD Division policy for the criteria that is reviewed to determine if it meets a “high” GER.

All medication errors are assessed for harm/risk of harm by the participant's physician, nurse, and/or pharmacist (preferably a medical person with knowledge of the participant).

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 management system. Further investigation and follow-up is determined by the DD Division and P & A. Practices or conditions that suggest systemic issues with a provider's medication administration practices must be addressed with a plan of remediation approved by the Division and P&A. Substantiated medication errors are included in a database to allow determination of trends.

In addition, monitoring of all service providers is conducted 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 management system.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 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 they have been informed of their rights, including the right to be free of A, N, and E and reporting procedures. D: Total # of ISPs reviewed from sample.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Case file review**

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| *(check each that applies):* | | |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☒ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☒ **Representative Sample**<br>Confidence Interval =<br>95% Confidence Interval, +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**(G-2) Number and percentage of unexplained deaths where proper follow-up(e.g reporting, referral, investigation)was completed within required timelines. N: number of unexplained deaths where proper follow-up(e.g reporting, referral, investigation)was completed within required timelines D: total number of unexplained deaths.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Tracking system and web-based management 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-3) 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**

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| *(check each that applies):* | | |
|---|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>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.*

**Performance Measure:**
**(G-4) Number and percent of serious events that were reported, initiated, reviewed, and completed within required time frames as specified in DD policy. N: number of serious events that were reported, initiated, reviewed, and completed within required time frames as specified in DD policy. D: Total number of serious events.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Tacking system and web-based management 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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% Confidence Interval, +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-5) Number and percent of investigated ANE/Serious event reports where risk**

**management steps were implemented. N: number investigated ANE/Serious event reports where risk management steps were implemented D: all investigated ANE/Serious event reports**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Tracking system and web-based management 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 = 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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-6) Number and percent of incident reports that are reported per DD Policy. N: Number of incident reports that are reported per DD Policy. D: Total number incident reports.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Web-based management 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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | 95% confidence level; 5% confidence interval |
| ☐ **Other**<br>Specify: | ☒ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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.*

**Performance Measure:**
**(G-7) Number and percent of 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 restraints reported.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Tracking system and web based management 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**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-8) Number and percent of restrictive interventions that were substantiated through investigation, where follow-up is completed as required. N: Number of restrictive interventions that are substantiated through investigation, where follow-up is completed as required. D: Total number of restrictive interventions reported**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:
**Tracking system and web-based management 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

**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.*

**Performance Measure:**
**(G-9) Number and percent 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 management 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: |

**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 States 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.

Resolution of substantiated incidents could result in continued monitoring, removal of client from residences, referral to law enforcement, termination of providers, etc.

(G-1) At the time of the case file review, signed ISP is reviewed for completion. The DDPA addresses the corrective action with the respective DDPM. The DD Division verifies that corrections are made.

(G-2) The DD Division will verify that all substantiated reports had recommended follow up completed. For those that do not have the recommendations completed, the DD Division will work with the provider and/or the DDPM to complete the recommendations.

(G-3) The DD Division will verify that all substantiated reports had recommended follow up completed. For those that do not have the recommendations completed, the DD Division will work with the provider and/or the DDPM to complete the recommendations.

(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 present future choking incidents from occurring.

**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**<br>Specify: | ☒ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.

## Appendix H: Quality Improvement Strategy (1 of 3)

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; and
- 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.

## 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**<br>Specify: | ☒ **Other**<br>Specify:<br>Semi Annually and On-going |

**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, DD service providers, families, waiver participants, the public, and other interested parties.

**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 H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):***

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

**b. Specify the type of survey tool the state uses:**

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

## *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).*

*All providers must maintain service authorization documentation provided by the Department for each client, client progress notes detailing goals and outcomes achieved with respect to the person-centered service plan, and daily census records, including duration of service, staff member delivering the service, and the type of day (i.e., hospital, absent, etc.). Providers licensed by the Department must additionally maintain any bills submitted to the Division for payment, document the right to receive payment, calculate, and report designated quality and performance indicators, maintain licenses and certification to demonstrate staff qualifications, and document compliance with assurances and guarantees defined in North Dakota Administrative Code Chapter (NDAC) 75-04-01.*

*The DD Division annually reviews a sample of claims from MMIS to ensure the integrity of provider billings of Medicaid payments for waiver services. Every audit will start by reviewing previous year's utilization and determining what the sample size is based on a 95% confidence interval and a 5% margin of error. Findings from the review are reported to the provider and the Program Integrity unit. Depending upon the results of the review, remediation measures will be taken when necessary.*

*For self-directed services the Fiscal Agent provides a monthly, or as requested, balance sheet report that indicates total budget, expenditures and remaining funds. This information is available to families and the Department. 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 annually and will share the results.In addition to the independent audit, self-directed services are included in the audits that the DD Division completes annually. During the audit, eligibility, time sheets, statements, and receipts are reviewed to ensure dates of services match units submitted on claims and authorization.*

*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.*

## *Appendix I: Financial Accountability*

### *Quality Improvement: Financial Accountability*

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

***a. Methods for Discovery: Financial Accountability Assurance:***
***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(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 claims paid with in individual's person-centered plan authorization. N: Number claims paid with in individual's person-centered plan authorization. D: Total number of claims paid.***

***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*** |
| ☐ ***Operating Agency*** | ☐ ***Monthly*** |
| ☐ ***Sub-State Entity*** | ☐ ***Quarterly*** |
| ☐ ***Other***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*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.*

***Performance Measure:***
***(I-2) Number and percent of provider payment rates that are consistent with the rate methodology in the approved waiver. N:Number of provider payment rates that are consistent with the rate methodology in the approved waiver. D:Total number of payment rates***

***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*** | ☐ ***Weekly*** | ☒ ***100% Review*** |

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

| ***Responsible Party for data aggregation and analysis*** *(check each that applies):* | ***Frequency of data aggregation and analysis****(check each that applies):* |
|---|---|
| | |

***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 States 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 or denied 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 advice with a code indicating the cause of the suspension or denial. The provider works with designated call center and the Department to correct the billing error.*

***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***<br>*Specify:* | ☐ ***Annually*** |
| | ☒ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*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).*

*Prior to beginning development of proposed waiver, the department held public hearings in all eight regional human service centers to solicit input. The Legislative process allows for public comment during appropriation committee hearings. Inflationary adjustments are determined by legislative appropriation and are subject to that public process.*

*The Department uses a fee for service system (for Residential Habilitation, Independent Habilitation, Day Habilitation, Individual Employment Support, Small Group Employment Support, and Prevocational Services) wherein the budget for a service is based on the maximum number of hours authorized for the client. The rate for each service is non-negotiable. These rates are determined based on legislative appropriations, and only updated when the legislature approves the amount of change. The initial rates went into effect April 1, 2018. To develop these rates the department contracted with a vendor who reviewed the provider general ledgers to determine the appropriate cost centers (components) for the expenses. The components are direct care staff, employment related costs, program supports, and general and administrative costs. After these were identified, the history of spending was analyzed using cost reports as well as information taken directly from the provides accounting systems. As the vendor did the analysis, they would report out to the steering committee which provided guidance. The steering committee, which was established in 2011, continues to meet on a regular basis to monitor the rate methodology and determine if any changes are necessary. At these meetings, the Department encourages all stakeholders to voice their concerns.*

*For Residential Habilitation, Independent Habilitation, Day Habilitation, Prevocational Services, Individual Employment Support and Small Group Employment Support, a standardized assessment tool is used to assess participants. Sections of the assessment score are factored into an algorithm to determine the average number of direct care staff hours in a 24-hour period needed by the individual per day of service. For each service, the client budget is calculated by multiplying the hourly rate from the rate matrix times the direct care staff hours identified through the algorithm utilizing the client's assessment. The hourly rates for these services include the following components: direct care staff wages, employment related expenses, program support, relief staff, and administrative costs. The Residential Habilitation hourly rate also contains an absence factor to account for temporary client absences. The state, within no more than 1 year, will submit to CMS an amendment to this waiver that revises the temporary absence factor in a manner that comports with CMS requirements.*

*Payment rates for Parenting Supports, Provider Managed In-Home Supports, Family Care Option, and Extended Home Health Care include the following components: administrative costs, program supervision and direct intervention time (direct support staff salary and fringes). The support hours needed are recommended by interdisciplinary teams and reviewed and approved by the Regional DD Program Administrator and the DD Division. Family Care Option is paid as a daily rate. Parenting Supports, Provider Managed In-Home Supports, and Extended Home Health Care are paid at an hourly rate.*

*Rates by Service Type*
*• Day Habilitation, Prevocational Services, and Small Group Employment Supports are paid for 15 minute units.*

*• Individual Employment Support is paid 15 minute units. The direct care staff wage accounts for client related activities outside of direct intervention time.*

*• Residential Habilitation is paid on a daily rate that based on the number of hours of daily service authorized for each client. Providers may only be reimbursed for the time spent providing habilitation to the client. Providers may receive a vacancy factor in the event of a vacancy for when an individual has permanently left the setting due to a client move or death. The vacancy factor is calculated using the service rate of the client who vacated the setting absent any additional services costs that individuals remaining in the setting will not receive. The vacancy factor may be offered until the vacancy is filled but no more than 90 consecutive days.*

*New residential facility care providers may receive a base staffing rate until fully occupied, or for three (3) months, whichever comes first.*

*• Independent Habilitation is paid 15 minute units based on the number or hours authorized for each client.*

*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 in July 2010. Adjustments are made based on legislatively approved inflationary increases.*

*Homemaker: the 15 minute unit fee for service agency and individual provider rate will be based on 90% of the current fee schedule. The agency fee for service rate was initially based on actual costs and includes allowable administrative costs to the agency. Allowable administrative costs include the indirect cost of providing services such as salaries, fringes, recruiting, telephone, billing, office space, utilities, janitorial, bonding, and liability insurance. The individual provider rate was initially established after considering the following information: minimum wage inflated by 30% to cover self-employment costs, the mean rate that was being paid to individuals who were currently providing waiver services and U.S. Bureau of Labor and Statistics information about the average salary paid in North Dakota for similar work.*

*Adult Foster Care (AFC): provider rates are determined based on a formula and factor based system (which is shown on a worksheet). This system considers the tasks required to care for specific clients. Each allowable task has an identified point factor. The total points are multiplied by a factor, which is unique to AFC. The factor formula then calculates a daily rate. Adult 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.The assigned daily rate takes into consideration the limit for AFC. If the rate is at the limit or less, the provider is notified of the assigned rate. If the rate is greater than the limit, the rate is reduced, and the provider is notified of the rate. The legislature provided an $8.00 per day plus 3% increase to the previous limits for these services in 2013.*

*Environmental Modifications, Equipment and Supplies, Behavioral Consultation, and Community Transition Services: The rates are determined by the individual within an individualized budget developed with the DDPM and reviewed/approved by the Regional DDPA and the DD Division.*

*Self-Directed Services In-Home Supports: The DDPM develops the client's individualized budget based on the amount and frequency as identified during the person-centered planning process, informal resources available to the client, the client's risk of unwanted out-of-home placement, additional client preferences, the maximum allowable hours for each self-directed service, and the service rate set in by the state legislative body. Clients are responsible for determining staff wages. They are free to choose a wage rate above the wage limits established by the State, but may not reallocate funds assigned to each service.*

**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 directly bill or invoice the Fiscal Agent. The Fiscal Agent pays the vendor, 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 management system. The subsequent checks described (numbered 1-7) are in place to assure services are received as billed.*

*The DD Claims reviewer receives semi-monthly queries of the web based management 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 waiver authorized, dates for which authorized, and Medicaid number.*

*Another file contains provider rates by provider number or service code. All clients have a service authorization entered into the MMIS that contains clients Medicaid number, name, date of birth, service authorized, dates for which service is authorized, provider number, units, and rate (if rate is not controlled by provider number or service code). 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 1) 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 claims and the reason. For Parenting Support, Provider Managed In-Home Supports, Family Care Option, Infant Development and self-directed services (In-Home Support, Equipment and Supplies, Environmental Modification, and Behavioral Consult) 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. For all other services an individual budget allocation (IBA) is created by the DDPM in the web based case management system. If the IBA requests outlier funding, the interdisciplinary team completes the outlier request form and provides documentation. The DDPA will review the outlier requests, forward to the Division for review, and the Division will gran approval as appropriate. The IBA houses the authorized amounts, dates of service, rate, and 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 determine 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:*

○ ***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 directly bill or invoice to the Fiscal Agent. The Fiscal Agent pays the vendor, codes the claims as to specific type, and bills through the state claims payment system. Monthly balance sheet reports are available for participants and the Department. The DDPM monitors individual budgets and account balances.*

☐ ***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:*

*One 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. Services provided are Day Habilitation, Residential Habilitation, Independent Habilitation, Prevocational Services, Individual Employment Support, and Small Group Employment Support.*

*County Social Service Boards may provide Homemaker Services. The rate is set in the same manner 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.***

- (●) ***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.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?1115 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. The room and board expenses are not included when determining the provider rate. 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 | 46059.83 | 8435.34 | 54495.17 | 203003.08 | 3968.57 | 206971.65 | 152476.48 |
| 2 | 49000.06 | 8688.40 | 57688.46 | 209093.18 | 4087.62 | 213180.80 | 155492.34 |
| 3 | 51943.81 | 8949.05 | 60892.86 | 215365.97 | 4210.25 | 219576.22 | 158683.36 |
| 4 | 54945.87 | 9217.52 | 64163.39 | 221826.95 | 4336.56 | 226163.51 | 162000.12 |
| 5 | 57958.04 | 9494.05 | 67452.09 | 228481.76 | 4466.66 | 232948.42 | 165496.33 |

# 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 | 5830 | 5830 |
| Year 2 | 5980 | 5980 |
| Year 3 | 6130 | 6130 |

| 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 4 | 6280 | 6280 |
| Year 5 | 6430 | 6430 |

## 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 (year 3 of current waiver 4/1/16-3/31/17) was used to calculate average length of stay, which was 281.*

## 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 and methodology for these estimates is as follows:*

*The number of users estimated for waiver year (WY) 1 is based off a combination of various data sources including state fiscal year (SFY) 2017 spend downs, CMS 372 reports for 4/1/2014-3/31/2017, and the 19/21 biennium budget. The SFY 2017 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 19/21 biennium budget was developed based off of actual expenditures and utilization from the 17/19 biennium and increased for legislatively approved increases. The 372 data for 4/1/2014-3/31/2017 was used as a starting point for users. Because 372 reports for 4/1/17-3/31/19 are not available, the state used actual expenditures from the 2017 spenddowns and 19/21 biennium budget to determine the number of proposed users for this 5-year period. The increase in the utilization was determined by average increases and patterns during 4/1/14-7/31/18.*

*Prevocational Services, Small Group Employment, Independent Habilitation, and Individual Employment were new services as of 4/1/18 therefore no 372 data existed, and the State used actual utilization numbers from April 1, 2018- June 30, 2018. For Day Habilitation and Residential Habilitation, with the addition of the new services utilizing 372 data would not have accounted for the movement of individuals with in services therefore the State used actual utilization numbers from April 1, 2018- June 30, 2018.*

*Average costs per unit consists of:*

*Costs per unit for WY1 for Day Habilitation, Prevocational Services, Small Group Employment, Residential Habilitation, Extended Home Health, and Family Care Option are based off of the actual expenditures for the 17/19 biennium, the 19/21 projected budget and inflated by 3% for legislatively approved increases. For WY2 through WY5 the rates are inflated by 3% for legislatively approved increases. Prevocational Services, Small Group Employment, Independent Habilitation, and Individual Employment were new services as of 4/1/18 therefore no 372 data existed. For Day Habilitation and Residential Habilitation, with the addition of the new services utilizing 372 data would not have accounted for the movement of individuals with in services therefore the 17/19 expenditures along with projections for the 19/21 biennium were used. For the remaining services we used actual 17/19 expenditures and the budget projections for 19/21 biennium, as it reflected more accurately the utilization and cost of the services. Because this waiver year (April-March) is not in line with the State's fiscal year (July-June), the state did not include an inflationary increase for the first 3 months of WY 1 as providers did not receive an inflationary increase at the start of the State fiscal year.*

*Costs per unit for WY1 for In-Home Supports; Infant Development – Evaluation/Assessment, IFSP, Home Visit, and Consultation; Independent Habilitation, Individual Employment, and Parenting Supports uses SFY 2018 Budget Instruction rates and inflated by 3% for legislatively approved increases. For WY2 through WY5 the rates are inflated by 3% for legislatively approved increases. Because this waiver year (April-March) is not in line with the State's fiscal year (July-June), the state did not include an inflationary increase for the first 3 months of WY 1 as providers did not receive an inflationary increase at the start of the State fiscal year.*

*Community Transition Services is a new service and the State did not have any actual utilization data, the cost per unit was kept at the maximum paid amount of $3000 per person.*

*Costs per unit for WY1 for Self-Directed Supports – Behavioral Consult, Environmental Modification, and Equipment and Supplies, Adult Foster Care, and Homemaker uses WY3 – 372 report and inflated by 3% for legislatively approved increases. For WY2 through WY5 the rates are inflated by 3% for legislatively approved increases. Because this waiver year (April-March) is not in line with the State's fiscal year (July-June), the state did not include an inflationary increase for the first 3 months of WY 1 as providers did not receive an inflationary increase at the start of the State fiscal year.*

**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:*

*D' was calculated by using actual data from WY 3 with an estimated cost of all other services paid on behalf of waiver recipients averaging $7,719.53. This amount was then inflated by 3% for WY 4-5 of the current waiver to get us to the starting point for the wavier renewal. This does not include cost of prescribed drugs that are furnished to Medicare/ Medicaid eligible individuals under Part D. For WY1-WY5 this figure was inflated by 3% based on anticipated legislatively approved 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, which is from a data prob software that extracts claims data, is used to calculate the G factor. Factor G was calculated by using actual ICF data from 4/1/16-3/31/17 to get the average per participant. This amount was then inflated by 3% for WY 4-5 of the current waiver to get us to the starting point for the wavier renewal. The G factor is based on the current average Medicaid costs for ICF/IID services minus the average ICF/IID recipient liability. For WY1-WY5 this figure was inflated by 3% based on anticipated legislatively approved increases.*

***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. For WY1-WY5 this figure was inflated by 3% based on anticipated legislatively approved increases. This figure does not include the cost of prescribed drugs furnished to dual eligible under Medicare Part D.*

## 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 | |
|---|---|
| Day Habilitation | |
| Homemaker | |
| Independent Habilitation | |
| Individual Employment Support | |
| Prevocational Services | |
| Residential Habilitation | |
| Extended Home Health Care | |
| Adult Foster Care | |
| Behavioral Consultation | |
| Community Transition Services | |
| Environmental Modifications | |
| Equipment and Supplies | |
| Family Care Option | |
| In-Home Supports | |
| Infant Development | |
| Parenting Support | |
| Small Group Employment Support | |

## 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 |
|---|---|---|---|---|---|---|
| **Day Habilitation Total:** | | | | | | **54861145.60** |
| Day Habilitation | 15 minute | 1214 | 7360.00 | 6.14 | **54861145.60** | |
| **Homemaker Total:** | | | | | | **32526.00** |
| Homemaker | 15 minute | 9 | 650.00 | 5.56 | **32526.00** | |
| **Independent Habilitation Total:** | | | | | | **4129228.80** |
| Independent Habilitation | 15 minute | 309 | 1440.00 | 9.28 | **4129228.80** | |
| **Individual Employment Support Total:** | | | | | | **5544806.40** |
| Individual Employment Support | 15 minute | 378 | 1280.00 | 11.46 | **5544806.40** | |
| **Prevocational Services Total:** | | | | | | **24673958.40** |
| Prevocational Services | 15 minute | 546 | 7360.00 | 6.14 | **24673958.40** | |
| **Residential Habilitation Total:** | | | | | | **104311674.00** |
| Residential Habilitation | day | 1285 | 360.00 | 225.49 | **104311674.00** | |
| **Extended Home Health Care Total:** | | | | | | **880951.36** |
| Extended Home Health Care | hour | 8 | 2251.00 | 48.92 | **880951.36** | |
| **Adult Foster Care Total:** | | | | | | **696510.40** |
| Adult Foster Care | day | 29 | 340.00 | 70.64 | **696510.40** | |
| **Behavioral Consultation Total:** | | | | | | **316946.76** |
| Behavioral Consultation | hour | 137 | 13.00 | 177.96 | **316946.76** | |
| **Community Transition Services Total:** | | | | | | **45000.00** |
| Community Transition Services | item | 15 | 1.00 | 3000.00 | **45000.00** | |
| **Environmental Modifications Total:** | | | | | | **435752.48** |
| Environmental Modifications | item | 46 | 4.00 | 2368.22 | **435752.48** | |
| **Equipment and Supplies Total:** | | | | | | **348496.26** |
| Equipment and Supplies | item | 238 | 3.00 | 488.09 | **348496.26** | |

| | |
|---|---|
| **GRAND TOTAL:** | **268528804.99** |
| **Total Estimated Unduplicated Participants:** | **5830** |
| **Factor D (Divide total by number of participants):** | **46059.83** |
| **Average Length of Stay on the Waiver:** | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Family Care Option Total:** | | | | | | **345568.44** |
| Family Care Option | day | 14 | 282.00 | 87.53 | **345568.44** | |
| **In-Home Supports Total:** | | | | | | **36286305.12** |
| In-Home Supports | hour | 1633 | 624.00 | 35.61 | **36286305.12** | |
| **Infant Development Total:** | | | | | | **19331628.73** |
| Consultations | consultations | 1739 | 4.00 | 295.50 | **2055498.00** | |
| Evaluations/Assessments | evaluations/assessments | 2015 | 1.00 | 486.71 | **980720.65** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 2304 | 3.00 | 471.37 | **3258109.44** | |
| Home Visits | Home Visits | 2548 | 36.00 | 142.13 | **13037300.64** | |
| **Parenting Support Total:** | | | | | | **64952.64** |
| Parenting Support | hour | 12 | 152.00 | 35.61 | **64952.64** | |
| **Small Group Employment Support Total:** | | | | | | **16223353.60** |
| Small Group Employment Support | 15 minute | 359 | 7360.00 | 6.14 | **16223353.60** | |
| | | | | **GRAND TOTAL:** | | **268528804.99** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5830** |
| | | | | **Factor D (Divide total by number of participants):** | | **46059.83** |
| | | | | **Average Length of Stay on the Waiver:** | | 281 |

## 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 |
|---|---|---|---|---|---|---|
| **Day Habilitation Total:** | | | | | | **57080995.20** |
| Day Habilitation | 15 minute | 1233 | 7360.00 | 6.29 | **57080995.20** | |
| **Homemaker Total:** | | | | | | **36985.00** |
| | | | | **GRAND TOTAL:** | | **293020376.58** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5980** |
| | | | | **Factor D (Divide total by number of participants):** | | **49000.06** |
| | | | | **Average Length of Stay on the Waiver:** | | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Homemaker | 15 minute | 10 | 650.00 | 5.69 | 36985.00 | |
| **Independent Habilitation Total:** | | | | | | 4341081.60 |
| Independent Habilitation | 15 minute | 318 | 1440.00 | 9.48 | 4341081.60 | |
| **Individual Employment Support Total:** | | | | | | 5915673.60 |
| Individual Employment Support | 15 minute | 394 | 1280.00 | 11.73 | 5915673.60 | |
| **Prevocational Services Total:** | | | | | | 26156336.00 |
| Prevocational Services | 15 minute | 565 | 7360.00 | 6.29 | 26156336.00 | |
| **Residential Habilitation Total:** | | | | | | 115709248.80 |
| Residential Habilitation | day | 1394 | 360.00 | 230.57 | 115709248.80 | |
| **Extended Home Health Care Total:** | | | | | | 1013355.18 |
| Extended Home Health Care | hour | 9 | 2251.00 | 50.02 | 1013355.18 | |
| **Adult Foster Care Total:** | | | | | | 761304.20 |
| Adult Foster Care | day | 31 | 340.00 | 72.23 | 761304.20 | |
| **Behavioral Consultation Total:** | | | | | | 361938.33 |
| Behavioral Consultation | hour | 153 | 13.00 | 181.97 | 361938.33 | |
| **Community Transition Services Total:** | | | | | | 45000.00 |
| Community Transition Services | item | 15 | 1.00 | 3000.00 | 45000.00 | |
| **Environmental Modifications Total:** | | | | | | 523046.16 |
| Environmental Modifications | item | 54 | 4.00 | 2421.51 | 523046.16 | |
| **Equipment and Supplies Total:** | | | | | | 402749.49 |
| Equipment and Supplies | item | 269 | 3.00 | 499.07 | 402749.49 | |
| **Family Care Option Total:** | | | | | | 403778.88 |
| Family Care Option | day | 16 | 282.00 | 89.49 | 403778.88 | |
| **In-Home Supports Total:** | | | | | | 41859454.00 |
| In-Home Supports | hour | 1811 | 635.00 | 36.40 | 41859454.00 | |

| | |
|---|---|
| GRAND TOTAL: | 293020376.58 |
| Total Estimated Unduplicated Participants: | 5980 |
| Factor D (Divide total by number of participants): | 49000.06 |
| Average Length of Stay on the Waiver: | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Infant Development Total:** | | | | | | **20838220.54** |
| Consultations | consultations | 1803 | 4.00 | 302.16 | **2179177.92** | |
| Evaluations/Assessments | Evaluations/Assesments | 2156 | 1.00 | 497.66 | **1072954.96** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 2466 | 3.00 | 481.97 | **3565614.06** | |
| Home Visits | Home Visits | 2680 | 36.00 | 145.32 | **14020473.60** | |
| **Parenting Support Total:** | | | | | | **71926.40** |
| Parenting Support | hour | 13 | 152.00 | 36.40 | **71926.40** | |
| **Small Group Employment Support Total:** | | | | | | **17499283.20** |
| Small Group Employment Support | 15 minute | 378 | 7360.00 | 6.29 | **17499283.20** | |
| | | | | **GRAND TOTAL:** | | **293020376.58** |
| | | | | **Total Estimated Unduplicated Participants:** | | **5980** |
| | | | | **Factor D (Divide total by number of participants):** | | **49000.06** |
| | | | | **Average Length of Stay on the Waiver:** | | 281 |

## 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 |
|---|---|---|---|---|---|---|
| **Day Habilitation Total:** | | | | | | **59250649.60** |
| Day Habilitation | 15 minute | 1252 | 7360.00 | 6.43 | **59250649.60** | |
| **Homemaker Total:** | | | | | | **41613.00** |
| Homemaker | 15 minute | 11 | 650.00 | 5.82 | **41613.00** | |
| **Independent Habilitation Total:** | | | | | | **4567536.00** |
| Independent Habilitation | 15 minute | 327 | 1440.00 | 9.70 | **4567536.00** | |
| | | | | **GRAND TOTAL:** | | **318415582.14** |
| | | | | **Total Estimated Unduplicated Participants:** | | **6130** |
| | | | | **Factor D (Divide total by number of participants):** | | **51943.81** |
| | | | | **Average Length of Stay on the Waiver:** | | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Individual Employment Support Total:** | | | | | | 6292352.00 |
| Individual Employment Support | 15 minute | 410 | 1280.00 | 11.99 | 6292352.00 | |
| **Prevocational Services Total:** | | | | | | 27637683.20 |
| Prevocational Services | 15 minute | 584 | 7360.00 | 6.43 | 27637683.20 | |
| **Residential Habilitation Total:** | | | | | | 127559610.00 |
| Residential Habilitation | day | 1503 | 360.00 | 235.75 | 127559610.00 | |
| **Extended Home Health Care Total:** | | | | | | 1151386.50 |
| Extended Home Health Care | hour | 10 | 2251.00 | 51.15 | 1151386.50 | |
| **Adult Foster Care Total:** | | | | | | 828709.20 |
| Adult Foster Care | day | 33 | 340.00 | 73.86 | 828709.20 | |
| **Behavioral Consultation Total:** | | | | | | 408773.82 |
| Behavioral Consultation | hour | 169 | 13.00 | 186.06 | 408773.82 | |
| **Community Transition Services Total:** | | | | | | 45000.00 |
| Community Transition Services | item | 15 | 1.00 | 3000.00 | 45000.00 | |
| **Environmental Modifications Total:** | | | | | | 614048.00 |
| Environmental Modifications | item | 62 | 4.00 | 2476.00 | 614048.00 | |
| **Equipment and Supplies Total:** | | | | | | 459270.00 |
| Equipment and Supplies | item | 300 | 3.00 | 510.30 | 459270.00 | |
| **Family Care Option Total:** | | | | | | 464504.76 |
| Family Care Option | day | 18 | 282.00 | 91.51 | 464504.76 | |
| **In-Home Supports Total:** | | | | | | 47823754.68 |
| In-Home Supports | hour | 1989 | 646.00 | 37.22 | 47823754.68 | |
| **Infant Development Total:** | | | | | | 22403541.62 |
| Consultations | Consultations | 1867 | 4.00 | 308.96 | 2307313.28 | |
| Evaluations/Assessments | Evaluations/Assessments | 2297 | 1.00 | 508.86 | 1168851.42 | |

| | |
|---|---|
| **GRAND TOTAL:** | 318415582.14 |
| **Total Estimated Unduplicated Participants:** | 6130 |
| **Factor D (Divide total by number of participants):** | 51943.81 |
| **Average Length of Stay on the Waiver:** | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| IFSP/IFSP Review | IFSP/IFSP Review | 2628 | 3.00 | 492.81 | 3885314.04 | |
| Home Visits | Home Visits | 2812 | 36.00 | 148.59 | 15042062.88 | |
| **Parenting Support Total:** | | | | | | 79204.16 |
| Parenting Support | hour | 14 | 152.00 | 37.22 | 79204.16 | |
| **Small Group Employment Support Total:** | | | | | | 18787945.60 |
| Small Group Employment Support | 15 minute | 397 | 7360.00 | 6.43 | 18787945.60 | |
| | | | GRAND TOTAL: | | | 318415582.14 |
| | | | Total Estimated Unduplicated Participants: | | | 6130 |
| | | | Factor D (Divide total by number of participants): | | | 51943.81 |
| | | | Average Length of Stay on the Waiver: | | | 281 |

## 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 |
|---|---|---|---|---|---|---|
| **Day Habilitation Total:** | | | | | | 61553004.80 |
| Day Habilitation | 15 minute | 1271 | 7360.00 | 6.58 | 61553004.80 | |
| **Homemaker Total:** | | | | | | 46332.00 |
| Homemaker | 15 minute | 12 | 650.00 | 5.94 | 46332.00 | |
| **Independent Habilitation Total:** | | | | | | 4794854.40 |
| Independent Habilitation | 15 minute | 336 | 1440.00 | 9.91 | 4794854.40 | |
| **Individual Employment Support Total:** | | | | | | 6685132.80 |
| Individual Employment Support | 15 minute | 426 | 1280.00 | 12.26 | 6685132.80 | |
| **Prevocational Services Total:** | | | | | | 29202566.40 |
| Prevocational Services | | | | | 29202566.40 | |
| | | | GRAND TOTAL: | | | 345060038.88 |
| | | | Total Estimated Unduplicated Participants: | | | 6280 |
| | | | Factor D (Divide total by number of participants): | | | 54945.87 |
| | | | Average Length of Stay on the Waiver: | | | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | 15 minute | 603 | 7360.00 | 6.58 | | |
| **Residential Habilitation Total:** | | | | | | **139891939.20** |
| Residential Habilitation | day | 1612 | 360.00 | 241.06 | **139891939.20** | |
| **Extended Home Health Care Total:** | | | | | | **1295000.30** |
| Extended Home Health Care | hour | 11 | 2251.00 | 52.30 | **1295000.30** | |
| **Adult Foster Care Total:** | | | | | | **898807.00** |
| Adult Foster Care | day | 35 | 340.00 | 75.53 | **898807.00** | |
| **Behavioral Consultation Total:** | | | | | | **457527.20** |
| Behavioral Consultation | hour | 185 | 13.00 | 190.24 | **457527.20** | |
| **Community Transition Services Total:** | | | | | | **45000.00** |
| Community Transition Services | item | 15 | 1.00 | 3000.00 | **45000.00** | |
| **Environmental Modifications Total:** | | | | | | **708878.80** |
| Environmental Modifications | item | 70 | 4.00 | 2531.71 | **708878.80** | |
| **Equipment and Supplies Total:** | | | | | | **518137.47** |
| Equipment and Supplies | item | 331 | 3.00 | 521.79 | **518137.47** | |
| **Family Care Option Total:** | | | | | | **527734.80** |
| Family Care Option | day | 20 | 282.00 | 93.57 | **527734.80** | |
| **In-Home Supports Total:** | | | | | | **54172507.95** |
| In-Home Supports | hour | 2167 | 657.00 | 38.05 | **54172507.95** | |
| **Infant Development Total:** | | | | | | **24029480.96** |
| Consultations | Consultations | 1931 | 4.00 | 315.91 | **2440088.84** | |
| Evaluations/Assessments | Evaluations/Assesments | 2438 | 1.00 | 520.32 | **1268540.16** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 2790 | 3.00 | 503.90 | **4217643.00** | |
| Home Visits | Home Visits | 2944 | 36.00 | 151.94 | **16103208.96** | |
| **Parenting Support Total:** | | | | | | **86754.00** |

| | |
|---|---|
| **GRAND TOTAL:** | **345060038.88** |
| **Total Estimated Unduplicated Participants:** | **6280** |
| **Factor D (Divide total by number of participants):** | **54945.87** |
| **Average Length of Stay on the Waiver:** | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Parenting Support | hour | 15 | 152.00 | 38.05 | 86754.00 | |
| **Small Group Employment Support Total:** | | | | | | 20146380.80 |
| Small Group Employment Support | 15 minute | 416 | 7360.00 | 6.58 | 20146380.80 | |
| | | | GRAND TOTAL: | | | 345060038.88 |
| | | | Total Estimated Unduplicated Participants: | | | 6280 |
| | | | Factor D (Divide total by number of participants): | | | 54945.87 |
| | | | Average Length of Stay on the Waiver: | | | 281 |

## 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 |
|---|---|---|---|---|---|---|
| **Day Habilitation Total:** | | | | | | 63802368.00 |
| Day Habilitation | 15 minute | 1290 | 7360.00 | 6.72 | 63802368.00 | |
| **Homemaker Total:** | | | | | | 51376.00 |
| Homemaker | 15 minute | 13 | 650.00 | 6.08 | 51376.00 | |
| **Independent Habilitation Total:** | | | | | | 5037552.00 |
| Independent Habilitation | 15 minute | 345 | 1440.00 | 10.14 | 5037552.00 | |
| **Individual Employment Support Total:** | | | | | | 7094630.40 |
| Individual Employment Support | 15 minute | 442 | 1280.00 | 12.54 | 7094630.40 | |
| **Prevocational Services Total:** | | | | | | 30763622.40 |
| Prevocational Services | 15 minute | 622 | 7360.00 | 6.72 | 30763622.40 | |
| **Residential Habilitation Total:** | | | | | | 152709148.80 |
| Residential Habilitation | day | 1721 | 360.00 | 246.48 | 152709148.80 | |
| | | | GRAND TOTAL: | | | 372670206.67 |
| | | | Total Estimated Unduplicated Participants: | | | 6430 |
| | | | Factor D (Divide total by number of participants): | | | 57958.04 |
| | | | Average Length of Stay on the Waiver: | | | 281 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Extended Home Health Care Total:** | | | | | | **1444601.76** |
| Extended Home Health Care | hour | 12 | 2251.00 | 53.48 | **1444601.76** | |
| **Adult Foster Care Total:** | | | | | | **971553.40** |
| Adult Foster Care | day | 37 | 340.00 | 77.23 | **971553.40** | |
| **Behavioral Consultation Total:** | | | | | | **508280.76** |
| Behavioral Consultation | hour | 201 | 13.00 | 194.52 | **508280.76** | |
| **Community Transition Services Total:** | | | | | | **45000.00** |
| Community Transition Services | item | 15 | 1.00 | 3000.00 | **45000.00** | |
| **Environmental Modifications Total:** | | | | | | **807668.16** |
| Environmental Modifications | item | 78 | 4.00 | 2588.68 | **807668.16** | |
| **Equipment and Supplies Total:** | | | | | | **579413.58** |
| Equipment and Supplies | item | 362 | 3.00 | 533.53 | **579413.58** | |
| **Family Care Option Total:** | | | | | | **593536.68** |
| Family Care Option | day | 22 | 282.00 | 95.67 | **593536.68** | |
| **In-Home Supports Total:** | | | | | | **60935294.00** |
| In-Home Supports | hour | 2345 | 668.00 | 38.90 | **60935294.00** | |
| **Infant Development Total:** | | | | | | **25716803.93** |
| Consultations | Consultations | 1995 | 4.00 | 323.02 | **2577699.60** | |
| Evaluations/Assessments | Evaluations/Assessments | 2579 | 1.00 | 532.03 | **1372105.37** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 2952 | 3.00 | 515.25 | **4563054.00** | |
| Home Visits | Home Visits | 3076 | 36.00 | 155.36 | **17203944.96** | |
| **Parenting Support Total:** | | | | | | **94604.80** |
| Parenting Support | hour | 16 | 152.00 | 38.90 | **94604.80** | |
| **Small Group Employment Support Total:** | | | | | | **21514752.00** |
| Small Group Employment Support | 15 minute | 435 | 7360.00 | 6.72 | **21514752.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **372670206.67** |
| **Total Estimated Unduplicated Participants:** | **6430** |
| **Factor D (Divide total by number of participants):** | **57958.04** |
| **Average Length of Stay on the Waiver:** | 281 |