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:

The renewal will extend the waiver for five years and will continue to
provide case management services, respite, skilled nursing, hospice, palliative care,
expressive therapy, equipment & supplies and bereavement counseling to eligible waiver participants and their families.
State has identified a shortage of available Hospice agencies in rural areas-there are the 22 Hospice agencies currently providing hospice service. Each agency only covers certain counties across the state http://www.ndhospice.com/locator.html
waiver was also updated to reflect new name of DHS to Department of Health and Human Services (DHHS)
also added; ongoing monitoring and compliance to the transition plan.
and revised assurances as were agreed upon within the CMS quality review.

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*):

Children's Hospice

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**

Waiver Number:ND.0834.R03.00
Draft ID: ND.011.03.00

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

Regular Waiver

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

07/01/23

Approved Effective Date: 07/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

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.

The purpose of this waiver is to keep children, who have a life limiting diagnosis that maybe less than one year, between the ages of 0 to their 22nd birthday, in their home as much as possible, avoiding lengthy hospital stays and delay or divert institutional care. These children would qualify for Nursing Home Level of Care. This waiver would remove the hospice requirement of a physician certification that death is expected within six months. The waiver would allow the family to provide treatments that are both curative and palliative for the child to successfully handle each day from time of diagnosis to death.

Children and their family would have access to the following services through this waiver: Case Management,Respite, Hospice, Skilled Nursing, Palliative, Bereavement Counseling, Expressive Therapies- for effective child and siblings, and Equipmant and Supplies. Children on the waiver will also have access to all Medicaid State Plan services. The service: Case Management, Hospice, Skilled Nursing and Palliative will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan.

This will be a traditional service delivery method waiver. The application for services comes to Medical Services; the Level of Care is completed by the Program Manager. This is followed by the family identifying the Hospice of choice, and the Hospice Physician confirming the diagnosis. The Hospice case manager sets up a meeting, oversees development of Service Plan and ensures implementation including sending the plan to Medical Services for authorization.

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:

On 02/28/2023 the Medicaid Medical Advisory Committee members were notified of the State Medicaid Agency's intent to request a five-year renewal for the Children’s Hospice waiver. On 03/01/2023 DHS sent a notice to all Tribal Chairman, Tribal Health Directors and IHS Representatives in ND notifying them of the intent to renew the waiver. Tribal organizations were notified that they could view the waiver on the DHHS website or receive a copy upon request. The tribal consultation notification letter was also posted to the DHHS website. ON 02/14/2023 the Tribal Advisory group was informed of the request for a five-year renewal of waiver. The required 30-day public comment period was provided. Public comment accepted from 03/01/2023 until 03/30/2023 at 5:00 pm CST. DHHS provided opportunities for public comment on the renewal in the following manner: 1) The waiver and public notice was posted to the DHS website https://www.hhs.nd.gov/waivers. 2) A press release was issued Statewide notifying the public of the opportunity for public comment. The public notice and press release included information on how to access the waiver application online or request a hard copy and contained information on how to submit public comments by either email, call in or written comments mailed in. Public Comment can be found at https://www.hhs.nd.gov/events/public-notice-five-year-renewal-medicaid-childrens-hospice-waiver. Press release can be found at https://www.hhs.nd.gov/news/health-and-human-services-seeks-comments-five-year-renewal-medicaid-childrens-hospice-waiver

As of 5:00pm central time on 03/30/2023, there were no comments received concerning the renewal to the Children's Hospice waiver.

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: Barchenger

First Name: Katherine

Title: Program Administrator of HCBS

Agency: Department of Human Services

Address: 600 E. Boulevard Ave, Department 325

Address 2:

City: Bismarck

State: **North Dakota**

Zip: 58505

Phone: (701) 328-4630 **Ext:** ☐ **TTY**

Fax: (701) 328-1544

E-mail: kbarchenger@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: Kathy Barchenger

State Medicaid Director or Designee

Submission Date: Jun 26, 2023

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

Last Name: Barchenger

First Name: Katherine

Title: State Autism Coordinator

Agency: ND DHHS

Address: 600 E Boulevard Ave Dept 325

Address 2:

City: Bismarck

State: North Dakota

Zip: 58505

Phone: (701) 328-4630 Ext: ☐ TTY

Fax: (701) 328-1544

E-mail: kbarchenger@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 renewal is subjected to provisions or requirements included in the State's completed home and community-based settings Statewide Transition Plan. Plan was updated on 12/16/2022 to include Ongoing Monitoring and Compliance.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

It is the intent of the North Dakota Department of Health & 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 Health & 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 Health & 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 Health & 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 Health & 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:

Medical Services

(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.

(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:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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.:*

The process of solicitation has already been completed. The Department maintains a contract with Maximus to complete skilled nursing facility level of care determinations that ensures eligibility criteria are met for participation in the waiver. Initial training has been done, as changes are made additional training is completed.

The Department maintains a contract with Noridian to conduct provider enrollment. The Department -Medical Services, provides ongoing oversight and annual review of provider enrollment to ensure compliance with provider requirements.

Maximus only ensures the individual meets Nursing facility - Level of Care. Medical Services reviews this determination, letter from Primary Care Provider, application to determine individual meets eligibility for waiver. Once child is determined to meet waiver eligibility requirements, the parents apply for Medicaid - initially full financial is reviewed to determine if Medicaid can assist the full family, if over income levels are determined, the reviewer looks for the screening entered into MMIS /FES system indicating the child meets waiver eligibility requirements allowing the reviewer to look to child's income and approve just the child for Medicaid enrollment.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The ND Department of Health & Human Services, Medical Services Division (Medicaid Agency representative) monitors the contract for the determination of Level of Careand for provider enrollment agreements.

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:

Monthly and annual reports regarding numbers and timeliness of Level of Care Determinations will be reviewed. Every 6 months a quality assurance report will be reviewed to determine if Level of Care decisions were supported by appropriate documentation. Feedback will be solicited from staff working with the Level of Care Determination process to measure satisfaction with current contractor.

All contracts are routinely monitored following the Department of Health & Human Services contract oversight procedures. Provider enrollment is monitored by the Medical Services Section and has monthly meetings with Noridian to review compliance and issues that come up as reported by program managers who complete oversight for the unique program's provider enrollments.

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	☒	☐
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☒
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐

Function	Medicaid Agency	Contracted Entity
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:
Number and percent of Level of Care determinations that were completed within three business days of the Department recieving the completed application. N: Number of level of cares determinations completed within three business days. D: Total number of level of cares determination.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all Hospice providers when caring for a child are carrying out

operational and administrative functions according to the policy and proceedure established for this waiver. N: number of Hospice providers carrying out operational and administrative functions according to the policy and procedure established. D: total number of hospice providers caring for children.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one-on-one technical assistance, training,amending the contract. Documentation is maintained by the State that describes the remediation efforts.

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:

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

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**	0	21	☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Child will have a letter from their primary physician stating they have a life limiting diagnosis that could possibly be end of life, within one year or less.
Program Manager will complete a Nursing Home Level of Care on the child with information provided by family and primary physician when the Level of Care requires further information to complete the determination, followed by a letter from a Hospice physician confirming the primary physician's diagnosis.

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:

Upon enrollment in the waiver families will be made aware both verbally and in writing of the maximum age of the program being the child's 22nd birthday. During the child's 21th year family and team will discuss and develop a written plan of how the transition into the adult services would be achieved. Team will look at the possibility of Medicaid State Plan / Adult Hospice / Home and Community Based Services / and guardianship needs, to mention a few. Plan will include list of services family is requesting/ application process and responsible person to assist family in obtaining services. Plan will also look at all areas of needs for child aging out of waiver.

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:

The cost is limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Department of Health & Human Services. Rates are published once per year. Current rates are available by contacting the Department of Health & Human Services Rate Setting Administrator.

Care plans for all waiver recipients must be submitted to the State Medicaid agency (SMA) when services are initiated, followed by every 6 months and every time services change. Reviewing the care plan and authorizing services includes assuring that the total cost of waivered services does not exceed the current highest monthly rate allowed to a nursing home within the rate setting structure of the Department of Human Services. SMA allows for reasonable modification to exceed the current highest monthly rate allowed to a nursing home for waivered services upon prior approval by Program Administration.

All individuals are allowed to ask for a reasonable modification. The reasonable modifications requests are individually viewed, and a decision is made based on the facts presented and whether the person is at risk of institutional placement if the accommodation is not made.

Programs and services administered and supervised by the department, directly or through contractual agreements, must be made available without regard to race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage.

○ **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)

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:

Through the intake and referral process, needs will be identified by the legally responsible caregiver and minor child, who has met the Nursing Home Level of Care criteria and has a letter from their primary physician stating a life limiting diagnosis along with confirmation from the Hospice physician; will be compared to services offered through the waiver. If the Program Manager determines the child's current health and welfare needs cannot be assured the family will be advised that they will not be referred to the Case Managing Service for authorization of Waiver services. The family will be advised of their right to appeal and steps to accomplish this.

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:

Request for short term exceptions will be reviewed at the Central Office and may be granted quarterly if additional supports will prevent long term out of home placements in nursing facilities and funding is available within Waiver budgets.
The Central Office is the state office. Case manager submits either an email of letter outlining why the need and length of time and how this exception will prevent a long term out of home placement. State Central Office review and send email either denying with appeal rights or approving.

☐ **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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	30
Year 2	30
Year 3	30
Year 4	30
Year 5	30

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	30
Year 2	30
Year 3	30
Year 4	30
Year 5	30

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).**

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:

Applications of possible waiver participants, requesting Hospice services, along with a letter from their Primary Physician stating the current primary diagnosis is of a life limiting nature of possibly less than one year, will be accepted by the Department. If all components are together a Nursing Home Level of Care will be completed. If approved, family will indicate which Hospice agency they wish to work with, and a letter confirming the diagnosis of the primary physician will be obtained from the Hospice physician. If it is determined the possible participant has a need that the services can assist with, the Hospice Agency will assign the participant to a Hospice Case Manager within the appropriate area, and one of family's choice. A mutually agreed upon meeting will take place with the Program Manager completing introductions if family is requesting.

The selection of who is on the waiver will be "first come first served".

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

○ **§1634 State**

○ **SSI Criteria State**

◉ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

◉ **No**

○ **Yes**

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

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

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

  Select one:

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

    Specify percentage:

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

  All other mandatory and optional groups except 42 CRF §435.110 and §435.116. Section 2302 of the affordable care act - concurrent hospice care for children in Medicaid. Hospice care (in accordance with section 1905(o) of the Act.

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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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: 677 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:

Hospice case management service will monitor progress of child monthly, followed by documented progress note. Waiver service must be utilized atleast quarterly and documented by case management. Services can be provided more frequently if need be.

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:

The Medical Service Program manager is a licensed Social worker completing the level of care with family. Maximus staff who complete the determination are employed through Maximus and are licensed practical nurses supervised by a registered nurse.

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.

The Level of Care instrument used by the State is entitled Level of Care Determination form. The completed document must be approved by the contract entity, Maximus, screening team to support that the individual meets the nursing facility level of care, as defined in North Dakota Administrative Code. (N.D.A.C.) 75-02-02-09.

This LoC form assesses the individual's health care needs, cognitive abilities, functional status and restorative potential.

The same documentation/ process is required for initial or re-evaluation of Level of Care.

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:

Information is gathered by the Program Manager within the Department of Health & Human Services. They will complete the Level of Care Determination form and a nursing facility level of care determination is made by Maximus, by either conference call or by mail notification. Maximus forwards a copy of the determination response to the Program Manager and to the family. This LoC form assesses the individual's health care needs, cognitive abilities, functional status and restorative potential. Department of Health & Human Services - Medical Services section, Program Manager reviews this determination, letter from Primary Care Provider, and application to determine individual meets eligibility for the waiver.

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):*

Program manager will receive a reminder in the MMIS system of Benefit plan expiring. This is where the dates of the LoC are entered in MMIS to ensure the individual is eligible for the waiver within MMIS. At this time a Level of Care will be completed by the Program Manager to ensure continued need.

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:

Paper copies of the Level of Care rating forms will be kept by the Medicaid State Agency. Electronic records will be interfaced into the MMIS system.

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:
Number and percent of level of care determinations entered into Maximus program that were completed within 2 working days of intake. N: Number of level of care determinations entered into Maximus program that were completed within 2 working days of intake. D: Total number of Level of cares completed for Children's Hospice waiver participants.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of applicants that received a Level of Cares evaluation. N: number of applicants that received a Level of Cares evaluation D: total number of applicants to the waiver.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

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:
Number and percent of initial LOC determinations being completed by using the approved form and using LOC criteria accurately. N: Number of initial LOC determinations being completed by using the approved form and using LOC criteria

accurately. D: total number of initial LOC's completed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Performance Measure:
Number and percent of Children Hospice initial Level of Care determinations made on Department of Health & Human Services - Medical Service division approved forms. N: number of Children Hospice initial Level of Care determinations made on Department of Health & Human Services - Medical Service division approved forms. D: total number of initial Level of Cares completed for Children's Hospice.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Children Hospice Waiver participant initial Level of Care determinations made by a qualified evaluator. N: Number of Children Hospice Waiver participant initial Level of Care determinations made by a qualified evaluator. D: All initial level of cares completed for Children Hospice.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

All data is held within Medical Services. The Central Office Administrator and the Assistant Director of the Long Term Care Continuum meet to review data and determine if the pattern represents a systemic problem which requires more holistic solutions. If it does then the Central Office Administrator is responsible to develop the change and to monitor the progress of change.

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 State staff to address individual problems which are resolved through various methods which may include but are not limited to providing one on one technical assistance, amending policy and/or procedures. Documentation is maintained by the State that describes the remediation efforts.

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:

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

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).

A Case plan is developed by the Family with assistance from Case Manager and Team of Professionals and others who know the child best, all traditional Medicaid, waiver and community service options are explored.

The individual authorization document allows the eligible consumers legally responsible caregiver to indicate they have been informed of the right to appeal if dissatisfied or not in agreement with services. This form also has the statement of agreement for choice of waiver verses institutional care.

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.

copies of the signed case plan and individual service authorization will be kept in the Medicaid office and the Hospice agency.

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):

When a consumer and/or their legally responsible caregiver are unable to independently communicate with the Central Office Administrator or their case manager, the services of an interpreter will be arranged. Written material may also be modified for non-English speaking consumers. The North Dakota Department of Health & Human Services has a Limited English Proficiency Implementation Plan to assist staff in communicating with all consumers.
The interpreter is used to translate the questions of the application that the state office reads. This is followed by the state office writing the answers the interpreter translates back to the state office. Time is also taken to ensure the family and or child understands the program and what will happen next. The Interpreter will also be used to inform the family of the determination and used by the case manager while development of plan. The agency providing the waiver service would then be required to provide this service to family while providing services.
The department's web site also provides information in 15 different languages.

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	**Case Management**		
Statutory Service	**Respite**		
Extended State Plan Service	**Hospice**		
Extended State Plan Service	**Skilled Nursing**		
Other Service	**Bereavement Counseling**		
Other Service	**Equipment and supplies**		
Other Service	**Expressive Therapy**		
Other Service	**Palliative**		

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:

Case Management

Alternate Service Title (if any):

Case Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
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):*

This service would assist the individual/family by providing information concerning stages of dying, be able to complete assessments to determine what stage of death the identified individual is in to determine possible services, provide information on what to expect with the identified terminal illness, be the link of communication for the hospice primary physician and family, to assist with referral and support. Hospice Case Management services would provide a variety of activities such as intake, case planning, on-going monitoring, review of supports/services to promote quality, monitor outcomes, planning for and implementing changes in supports and services to reflect the changes of the progression of death and providing information on the right to appeal. In addition to these the hospice case manager would also be available day or night, by either phone or in person, to assist the family in dealing with the terminal illness or with complications brought on by a stage of dying. Hospice case Manager would ensure the plan and discussion was focused on the terminal illness and the outcome of death. They would encourage and show through example how to talk about death and how the emotions and fears effect everyday life of a family dealing with this outcome.This service would assure that support for individual /family requests fall within the scope of the program, while promoting reasonable health and safety. Hospice case management services would assist in the coordination of identifying multiple services both formal and informal and with obtaining and applying for identified services. This service would ensure goal and needs are being met by meeting with the individual/family at least quarterly to review case plan and assure supports are successful in reaching the goal of the family. The Hospice Case manager will complete assessment in determination of where the individual is within the multiple stages of death and complete this assessment frequently to ensure the plan is current and beneficial to the family with authorized services.
Hospice case management services would ensure the review of rights are signed to include assistance of family being informed of their rights and to document the choice of services for individual/family at least quarterly this would include 1) review of progress, 2) satisfaction of services, 3) identify barriers and 4) discuss an action plan to resolve outstanding issues. Hospice case management services may consist of phone calls or accompany consumer to support agency, assisting with completing paperwork and any other assistance identified in service plan. Hospice case management services would be able to assist in crisis intervention services to include emergency planning -24 hour on call service. Hospice case management would also provide an emotional support and assistance to problem solving as needed.
This service can be authorized to be utilized during all other waiver services. This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan. The Hospice case manager cannot perform any other waiver service and is responsible to send the signed plans into the state program manager.
Case management that can be furnished under the state plan should be furnished as services required under EPSDT to waiver participants under age 21.

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

Hospice Case Management services can be used monthly. Hospice case manager cannot provide any other service within the waiver.
This service can be authorized to be utilized during all other waiver services.
This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan.

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	Hospice Case Manager
Individual	Hospice Case Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Hospice Case Manager

Provider Qualifications

License *(specify):*

Registered nurse in the state of ND, working at a licensed Hospice agency within the state of North Dakota as per Chater 23-17.4

Certificate *(specify):*

Other Standard *(specify):*

Must be available to family at all times, must have strong understanding of the stages of death and be able to assess what stage the individual is in, must have strong communication skills, must have access to primary hospice physicians to be able to communicate changes in identified individuals heath status. must be able to enroll as a Medicaid provider within the MMIS system.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Nursing. Department of Health.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Hospice Case Manager

Provider Qualifications

License *(specify):*

Registered Nurse in the state of North Dakota.

Certificate *(specify):*

Other Standard *(specify):*

independently working yet able to meet all requirements of service definition for case management. Must be available to family at all times, must have strong understanding of the stages of death and be able to assess what stage the individual is in, must have strong communication skills, must have access to primary hospice physicians to be able to communicate changes in identified individuals heath status. must be able to enroll as a Medicaid provider within the MMIS system.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Nursing.

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:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
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):*

Child must be residing in their legally responsible care givers home and service of respite must occur within this home. Respite can provide temporary relief to the legally responsible care giver in order for the care giver to possibly accompany other siblings to daily activities, provide relief for brief periods of time and complete all ADL's and IADL's for the child. This service will only be authorized when listed on the service plan as a need.
These are hours the family can use in conjunction with the Home Health Aide (not a waiver service). These hours may also be authorized if family is receiving home health services through state plan – they will not be scheduled during same times. Respite is defined as taking total care of child for a short period of time (not overnight). The legal caregiver will be able to attend to other siblings, family members, take care of self needs or other tasks. The service plan would state respite being used and number of hours per month. Service auths are approved for three-month time. So, they are approved four times a year.

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

Limited to 76 hours per year for identified child.
The number of hours needed by the family for respite are determined within the care plan by the individual’s team. These determined hours must be stated on Service Plan. Service auths are approved for three-month time, at a minimum they are approved four times a year. if changes in hours are needed a new auth is created and sent into the program manager for approval.
The ability to exceed the limit of 76 hours is available to the family by submitting a request to the program manager for review explaining why the needs cannot be met within the 76 hours. This request is reviewed every three months during the natural renewal of authorization of services.
Health and welfare of individual is monitored by the service manager monthly either through scheduled team meetings or conversations between parent, case manager and individual if appropriate. These conversations address the cares of the child, if services are meeting the identified need and are being provided within the scope of the service these conversations are documented on the care plan and within the service managers logs that are forwarded to the departments program manager.

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	Medicaid enrolled agency that has certified CNA's on their staff.
Agency	Hospice Agency
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Medicaid enrolled agency that has certified CNA's on their staff.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Individual providing the service must minimally have a CNA certificate.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Certification of CNA training completed/ dated.

Frequency of Verification:

every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Licensed Hospice agency within the state of North Dakota as per Chapter 23-17.4

Certificate *(specify):*

individual providing the service must minimally have a CNA certificate.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certified as a Home Health Care provider per chapter 23-17.3

Certificate *(specify):*

individual providing the service must minimally have a CNA certificate.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health

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:

Hospice

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
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):*

This service would be available to the family depending on the child's medical condition needs and progression of diagnosis. This services would mirror traditional hospice services except for the continued curative measures would be available, through the state plan. Team would determine needs and document need on the Service Plan. Skilled services would follow after the state plan has been maximized, allowing services to be preventive curative and restorative aspects of care that are performed by a professional care giver. These services may be accessed during times when legally responsible caregiver is not in the home.

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

Child and family would be able to utilize up to 74 days of waiver services per year, after state plan is maximized. This waiver service is not available if child needs palliative waiver services or is able to have skilled nursing services meet child's need. This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan.
The number of days needed by the family for hospice are determined within the care plan by the individual's team. These determined days must be stated on Service Plan. Service auths are approved for three-month time, at a minimum they are approved four times a year. If changes in days approved are needed a new auth is created and sent into the program manager for approval.
The ability to exceed the limit of 74 days is available to the family by submitting a request to the program manager for review explaining why the needs cannot be met within the 74 days. This request is reviewed every three months during the natural renewal of authorization of services.
Health and welfare of individual is monitored by the service manager monthly either through scheduled team meetings or conversations between parent, case manager and individual if appropriate. These conversations address the cares of the child, if services are meeting the identified need and are being provided within the scope of the service these conversations are documented on the care plan and within the service managers logs that are forwarded to the departments program manager.
Hospice that can be furnished under the state plan should be furnished as services required under EPSDT to waiver participants under age 21

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	Hospice Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Hospice

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Licensed Hospice agency within the state of North Dakota as per Chapter 23-17.4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Department of Health

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:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
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):*

A licensed practical nurse or a registered nurse means one who has met all legal requirements for licensure and holds a current license to practice in North Dakota pursuant to chapter 43-12.1. This service would be available depending on the child's medical condition and needs. Team would determine this need and document need on the Service Plan. Skilled nursing services would follow after the state plan funding has been maximized, services may be accessed during times when regular caregiver is not in the home and when cares are greater than the scope of the Home Health Aide.
Nursing waiver services can be used during the same time as Home Health Aide if state on Service Plan the need for both.

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

this service is limited to 194.5 hours per year and may only be used after child has maximized state plan service. Nursing waiver services can be used during the same times as Home Health Aide if stated on the Service Plan the need for both. this services is not available if child needs Hospice or Pallitive waiver service. This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan.
The number of hours needed by the family for Skilled Nursing are determined within the care plan by the individual’s team. These determined hours must be stated on Service Plan. Service auths are approved for three-month time, at a minimum they are approved four times a year. If changes in approved hours are needed a new auth is created and sent into the program manager for approval.
The ability to exceed the limit of 194.5 hours is available to the family by submitting a request to the program manager for review explaining why the needs cannot be met within the 194.5 hours. This request is reviewed every three months during the natural renewal of authorization of services.
Health and welfare of individual is monitored by the service manager monthly either through scheduled team meetings or conversations between parent, case manager and individual if appropriate. These conversations address the cares of the child, if services are meeting the identified need and are being provided within the scope of the service these conversations are documented on the care plan and within the service managers logs that are forwarded to the departments program manager.
Skilled Nursing services that can be furnished under the state plan should be furnished as services required under EPSDT to waiver participants under age 21.

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	Hospice Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Licensed Hospice agency within the state of North Dakota as per Charter 23-17.4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health

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:

Bereavement Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
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):*

Counseling of child and family in dealing with and adjusting to the possible loss of child to death and the aftercare of family due to the death of child.
Focus of counseling would be to mainly address, communication and coping with the multiple emotions surrounding a family with a child who has a life limiting diagnosis with the outcome of death, and in dealing with the loss of child for six months after the death of child.
This service can be authorized to be utilized during all other waiver services.

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

Counseling services are limited to 98 hours of services per year. Bereavement counseling is initiated and billed while the child is on the waiver but may continue up to six months following the death of the child. At time of authorization of this waiver service family would indicate if after care would be desired and placed on the Service Plan would indicate if these services would happen monthly or every other month for six months past death of child- these hours would be held back from the total 98 hours of service until after death.
6 months after death, program manager will complete a file audit to ensure services are rendered and paid in full. Upon completion of audit if services were found NOT to be used - agency will be contacted in writing stating findings and request for reimbursement of unused service payment.

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 Professional Counselor
Individual	Spiritual Counselor
Individual	Licensed Clinical Social Worker
Agency	Hospice Agency
Individual	Licensed Professional Clinical Counselor
Individual	Licensed Independent Social Worker
Individual	Licensed Psychologist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

North Dakota Board of Counseling Examiners

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Counseling Examiners

Frequency of Verification:

as required.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Spiritual Counselor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be employed by a Licensed Hospice Agency working with child and family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Hospice Agency licensed by the Department of Health

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

L.C.S.W. by the North Dakota Board of Social Work Examiners

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Board of Social Work Examiners

Frequency of Verification:

every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Licensed Hospice agency within the state of North Dakota as per chapter 23-17.4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Professional Clinical Counselor

Provider Qualifications

License *(specify):*

Licensed to practice by the North Dakota Board of Counseling Examiners

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Counseling Examiners

Frequency of Verification:

As Required.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Independent Social Worker

Provider Qualifications

License *(specify):*

L.I.S.W. from North Dakota Board of Social Work Examiners.

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.

Verification of Provider Qualifications

Entity Responsible for Verification:

Board of Social WOrk Examiners

Frequency of Verification:

Every Two Years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Psychologist

Provider Qualifications

License *(specify):*

Requires a doctorate degree in psychology and licensure or eligibility for licensure as a Licensed Psychologist Examiners

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Board of Psychologist Examiners

Frequency of Verification:

As required.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Equipment and supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
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):*

Equipment and supplies not covered through the state plan such as adaptive items for daily living, environmental control items, personal care items, alarms or alert items to name a few possibilities. Items that could be covered through this waiver include modifications to existing equipment, adaptive car seats, tumble chairs, alternative power sources, disposable wipes or items in excess of state plan limits. Focus of equipment would be easing of pain, assisting with child's independence, or strength building. Denial from Medicaid Durable Medical Equipment must be obtained before payment would be considered.
All items shall meet applicable standards of manufacture, design and installation.
Medical equipment and supplies that can be furnished under the state plan should be furnished as services required under EPSDT to waiver participants under age 21

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice agency
Agency	DME supplier

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:

Hospice agency
Provider Qualifications
License *(specify):*

Licensed Hospice agency within the state of North Dakota as per Chapter 23-17.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health

Frequency of Verification:

Annually

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:

DME supplier

Provider Qualifications

License *(specify):*

none

Certificate *(specify):*

none

Other Standard *(specify):*

none

Verification of Provider Qualifications

Entity Responsible for Verification:

none

Frequency of Verification:

none

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:

Expressive Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11130 other therapies
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):*

Expressive therapy is the use of art practices that give a child the ability to express and explore their own medical condition by the use of their imagination and multiple creative expressions. Therapist assist child and siblings in being able to express such things as; difficult feelings of coping, feeling alone, and being able to talk to others about medical conditions and possible outcomes. Focus of therapy would be on living with and coping with medical condition that is life limiting. Siblings will be able to attend sessions with affected child.
This service can be authorized to be utilized during all other waiver services.

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

Expressive therapy would be available for a total of 39 hours per year per child.
The number of hours needed by the family for Expressive Therapy are determined within the care plan by the individual's team. These determined hours must be stated on Service Plan. Service auths are approved for three-month time, at a minimum they are approved four times a year. If changes in hours are needed a new auth is created and sent into the program manager for approval.
The ability to exceed the limit of 39 hours is available to the family by submitting a request to the program manager for review explaining why the needs cannot be met within the 39 hours. This request is reviewed every three months during the natural renewal of authorization of services.
Health and welfare of individual is monitored by the service manager monthly either through scheduled team meetings or conversations between parent, case manager and individual if appropriate. These conversations address the cares of the child, if services are meeting the identified need and are being provided within the scope of the service these conversations are documented on the care plan and within the service managers logs that are forwarded to the departments program manager.

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	Licensened Phychologist
Individual	Licensed Independent Social Worker
Individual	Licensed Professional Clinical Counselor
Agency	Hopice Agency
Individual	Licensed Professional Counselor
Individual	Licensed Clinical Social Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Licensened Phychologist

Provider Qualifications

License *(specify):*

Requires a doctorate degree in psychology and licensure or eligibility for licensure as a Licensed Psychologist by the ND Board of Psychologist Examiners.

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.
Must have experience in providing Art, Music or Play therapy to children.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Board of Psychologist Examiners.

Frequency of Verification:

As required.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Licensed Independent Social Worker

Provider Qualifications

License *(specify):*

L.I.S.W. by the North Dakota Board of Social Work Examiners

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.
Must have experience in providing Art, Music or Play therapy to children.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Social Work Examiners

Frequency of Verification:

every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Licensed Professional Clinical Counselor

Provider Qualifications

License *(specify):*

Licensed in the state of ND by the North Dakota Board of Counseling Examiners

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.
Must have experience in providing Art, Music or Play therapy to children.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Counseling Examiners

Frequency of Verification:

As required.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Agency

Provider Type:

Hopice Agency

Provider Qualifications

License *(specify):*

License Hospice Agency within the state of North Dakota as per Chapter 23-17.4

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children. Must have experience in providing Art, Music, or Play therapy to children.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

North Dakota Board of Counseling Examiners.

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children.
Must have experience in providing Art, Music or Play therapy to children.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Counseling Examiners

Frequency of Verification:

as required.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

Licensed to practice within the state of North Dakota, by the ND Board of Social Work Examiners.

Certificate *(specify):*

Other Standard *(specify):*

Must have experience working with children. Must have experience in providing Art, Music or Play therapy to children.

Verification of Provider Qualifications

Entity Responsible for Verification:

North Dakota Board of Social Work.

Frequency of Verification:

Every two years.

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:

Palliative

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
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):*

Cares that is palliative and supportive in nature. Supportive medical, health and other care provided to child and their family to meet the special needs arising out of the physical, emotional, spiritual and social stresses experienced during the final stages of illness and during dying and bereavement so that when and where possible the child may remain at home, with homelike inpatient care utilized only if necessary. This service would look like traditional hospice except for the elimination of 6 month life requirement and family still being able to try/look for curative measures. Cares could be line of site nursing, pain management through alternative evidence based services, physical therapies or occupational therapies. This would be determined by the team and recorded on the Service Plan.

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

This would be limited to end of life cares for child and only after state plan has been maximized. This services is limited to 216 unit (54 hours) of services per year.
This waiver service is not available in conjunction with skilled nursing or hospice waiver services. This service will be covered under the state plan once child's possible passing is less than 6 months. This will be noted on the Service Plan.
The number of units needed by the family for Palliative cares are determined within the care plan by the individual's team. These determined hours must be stated on Service Plan. Service auths are approved for three-month time, at a minimum they are approved four times a year. If changes in units are needed a new auth is created and sent into the program manager for approval.
The ability to exceed the limit of 216 units is available to the family by submitting a request to the program manager for review explaining why the needs cannot be met within the 216 units. This request is reviewed every three months during the natural renewal of authorization of services.
Health and welfare of individual is monitored by the service manager monthly either through scheduled team meetings or conversations between parent, case manager and individual if appropriate. These conversations address the cares of the child, if services are meeting the identified need and are being provided within the scope of the service these conversations are documented on the care plan and within the service managers logs that are forwarded to the departments program manager.

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	Hospice Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Palliative

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Licensed Hospice Agency within the state of North Dakota as per Chapter 23-17.4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health

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:

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):

Staff must agree to give permission for a background check. Individual cannot work without an appropriate background check completed. This check will be conducted by the hiring Hospice agency, Human Service Center, Home Health Agency or agency individual works for.

If the individual has lived in North Dakota, for the last 5 years, a national check is not needed, only within state.
If the individual has lived outside North Dakota at any time during the last five years both the National and State check must be completed.
Upon request individuals wanting to provide services without being hired by an agency will provide the department proof of being a licensed RN within the state of ND.
Once a provider has been chosen by the family the program manager will ensure all individual working with the individual has completed the criminal background check by receiving a letter from the provider confirming this with dates of completion.

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):

The Child Abuse and Neglect Information Index are maintained by the Department of Health & Human Services, Children and Family Services Division. Home Health agency, Hospice Agency and Human Service Center will conduct screenings upon hiring individuals. Individuals cannot work without a completed abuse registry check.

Once a provider has been chosen by the family the program manager will ensure all individual working with the individual has completed the abuse registry check by receiving a letter from the provider confirming this with dates of completion.

For individual service providers - Board of Nursing registry (licensed nurses or Unlicensed Assistive Persons (UAPs); Health Dept's Certified Nurse Assistant's registry; Attorney General's Sexual Offender's registry, ND State Court website, and debarment database; Department of Health & Human Services HCBS provider complaint/termination database.

For agency service providers - debarment database; Department of Health & Human Services HCBS provider complaint/termination database. For newly enrolled service providers, the agency is responsible to assure direct service employees have met standards and requirements.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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/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:

The state responds to inquiries from potential providers and will solicit potential providers in areas with unmet needs. Any interested applicant interested in becoming a Licensed Hospice provider may obtain a Hospice Licensure Packet through the Department of Health and if they meet minimum criteria they will receive a desired license to provide hospice services. However if they are not interested in being licensed the Program Manager will ensure they meet minimum requirements of service descriptions, provider qualifications for service willing to provide.

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:
Number and percent of all providers that meet required licensure/ certification of agency beyond first year of waiver service. N: number of all providers that meet required licensure /certification of agency beyond first year. D: total number of providers beyond first year that require licensure /certification.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of new Hospice providers caring for children that provide proof of required licensure / certifications prior to initial waiver service. N: number of new Hospice providers caring for children that provide proof of required licensure / certifications prior to initial waiver service. D: total number of new hospice providers providing services to hospice children.

Data Source (Select one):
Other
If 'Other' is selected, specify:
submission of copy of licensure/ certifications by agency prior to start of services.

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of new providers-not hospice agencies-caring for children that provide proof of required licensure certifications prior to initial waiver service.N:number of new providers-not hospice agencies-caring for children that provide proof of required licensure certifications prior to initial waiver service.D:total number of new providers-not hospice agencies-providing services to hospice children

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all providers of Children's Hospice waiver that initially and continually adhere to all standards prior to their furnishing waiver services. N: Number of all providers of Children's Hospice waiver that initially and continually adhere to all standards prior to their furnishing waiver services. D: Total number of providers of Children's Hospice waiver.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors 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:
Number and percent of all non-licensed/non-certified providers that adhere to waiver requirements. N: number of all non-licensed/non-certified providers that adhere to waiver requirements. D: Total number of non-licensed/non-certified waiver providers.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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:

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

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:
Number and percent of waiver providers caring for children that meet individual agency provider training requirements in accordance with state requirements and approved waiver. N: Number of waiver providers caring for children that meet individual agency provider training requirements in accordance with state requirements and approved waiver. D:total number of waiver providers caring for children.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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.

All data is held within Medical Services. The central Office Administrator and the Assistant Director of the Long Term Care Continuum meet to review data and determine if the pattern represents a systemic problem which requires more holistic solutions. If it does then the Central Office Administrator is responsible to develop the change and to monitor the progress of change.

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 Department of Health & Human Service - Medical Service Section, Children's Hospice waiver Program Manager to address individual problems which are resolved through various methods which may include but are not limited to providing one on one technical assistance, amending policy and/or procedures. Documentation is maintained by the State that describes the remediation efforts.

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 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 ND State Medicaid Agency has done a review and analysis of all settings where Children's Hospice waiver services are provided to eligible clients and the settings where waiver participants reside. The analysis included review of ND Century Code, ND Administrative Code, CH policy and regulations.

Through this process, the state has determined that the current settings where waiver services are provided and where waiver participants reside, fully comply with the regulatory requirements because the services listed below are individually provided in the recipients privately owned residence and allow the client full access to community living. Recipients, with their family, get to choose what service and supports they want to receive and who provides them. Recipients, when 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.

Case Management
Respite
Specialized Equipment and Supplies
Skilled Nursing
Palliative Care
Hospice

The following waiver services are not provided in the individual's private residence but based on our analysis also fully comply because it is an individualized service that allows the client to access the community to receive essential services from a provider of their choosing.

Expressive therapy
Individual & Family Counseling

The State Medicaid agency will ensure continued compliance with the HCBS settings rule by implementing and enforcing policy that will ensure the continued integrity of the HCB characteristics that these services provide to waiver recipients. In addition, the State monitors all individual person-centered service plans, to assure clients are free to choose what services and supports they wish to receive and who provides them. The State will review all future settings where waiver services will be provided and where waiver participants will reside to ensure that the settings meet the home and community-based settings requirement.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Service Plan

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:

☐ **Social Worker**
Specify qualifications:

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

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:*

Currently there are zero independent Hospice Case Managers enrolled as providers for this waiver. Due to the geographic landscape of the state the only willing and qualified providers of Hospice Case Management are the same entities that also provide other hospice services. The current areas of Hospice agencies are as follows: Fargo /Grand Forks/ Lisbon/ Mayville/ Valley City/Minot/Devils Lake / Madan / Jamestown /Bismarck / Dickinson /Williston/ Rugby/ Hazen/ and Hettinger The Hospice agencies are situated regionally throughout the state and due to the rural nature of the state, participants do not currently have the ability to utilize providers from different agencies because of the distance between the agencies and the participants that they serve. Families are informed by the hospice state program manager prior to choosing the Hospice agency that the case management service will be provided from within the agency of their choice. The state is continually looking at recruiting Independent Registered Nurses to provide Hospice Case Management. The state has been attempting to recruit since 2019 but have yet to have any Independent Registered Nurses come forward for this service. The state has posted this opportunity in the provider newsletter frequently. If The waiver participant, family and/or legal caregiver is aware of a provider for Hospice case management who is outside of the hospice agency, they may select that individual provided that they meet the State's Medicaid provider qualifications for case management. The state will notify participants as new case management providers are enrolled to increase their choice of providers.

The state will inform participants that they may file a dispute to challenge the assertion that there are no other willing and qualified providers available. Family can identify and select an alternative independent hospice case manager at any time. Once the state is notified of the selection of an independent case manager, the state will confirm that the proposed individual can perform the tasks listed within the case management service and they were enrolled as a Medicaid provider, prior to rendering service for the individual.

All participant plans of care are sent to the state program manager to authorize and enter into MMIS for payment. A plan is not considered approved until it is authorized by the state program manager.

The plan must have the signature of the hospice case manager on the plan, along with any other direct service providers. A statement on the plan states the hospice case manager cannot perform other waiver services. The State Medicaid Agency requires a separation of who conducts the work. The person who provides case management cannot be the same person that provides direct waiver services to waiver recipients. All providers must keep service records that include the name of the person who provides the service including case management entities that also provide other HCB services. The plan is reviewed and approved directly by the State Program Manager to assure the entity completed the form according to state guidelines.

Yearly the participant is provided with a brochure listing all services and a right brochure listing what their rights are and if having difficulty of any kind with the case manager of choice to contact the program manager for assistance in either resolution or identifying alternative case manager. Protection and Advocacy contact information is also provided yearly. This information is provided by the departments program manager.

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.

Upon acceptance into waiver the family is provided with brochure of service to understand what is available, along with information to assist in the understanding of what is expected from a Person Centered plan of Care along with the option of having the departments program manager attend the first planning meeting. This would be given to the family while establishing eligibility and again prior to the first team meeting.

Family will also be informed in writing about the "Rights of Participant/ Legal Responsible Caregiver" this information will inform the Participant about the right to have who they feel is important to the participant/family to be included in the team along with those professionals that are involved in the care of child. Family will be informed they have the final determination in the plan and in who is part of the team. Safety and Health of child will be addressed by the whole team on an ongoing bases.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A)Who develops the plan, who participates in the process and the timing of the plan
The Service Plan is developed using a wraparound team approach, meaning the team will be made up of individuals that know the child and family best along with professionals involved with the child's care. The plan can only be updated/ changed if minimally the family and case manager are present with written copies of the plan being sent to the rest of the team. Decisions are made by consensus of team with family having final say. The case manager will continue to develop a paper service plan during the meeting with the planning team made up of individuals that know the child and family best along with professionals involved with the child's care. Case manager cannot change the Service Plan in any way without legal caregiver authorization. The plan is not approved until it is sent to the state program manager and signed.
The role of the Hospice case manager is to be the specially trained individual on the team to evaluate the cares for a terminally ill individual and communicate the needs to the Hospice physician, and arrange for other services to meet the family's needs. The uniqueness of the hospice case manager is they are available at all times of the day or night to assist the family during crises and in understanding the fears in dealing with the terminal illness or stage of dying. They must have strong communications skills and be very comfortable with talking about all aspects of death with no hesitation to the terminally ill individual and their family / caregiver. The Hospice case managers also have the training in identifying the stages of death and have the ability to communicate these stages to the hospice physician to be able to treat the symptoms correctly. The hospice case manager also communicates the possible needs of improving the patients comfort while going through the stages of death and possible complications of their terminal illness. They are trained in how to deal with the family /caregivers in assisting them in dealing with the emotions of having a terminally ill individual and assist them in recognizing the need to express their grief, learn to talk about the illness and assist them in finding appropriate help to meet these needs. In addition to these tasks they educate and train the caregiver in being able to recognize potential symptoms, changes within the stages and in being able to provide the terminally ill individual assistance where possible. They are also continually offering the individual and caregiver emotional and practical support to include finding services to meet identified needs during the process of death, and assisting the family in communication and voicing concerns to the primary hospice physician, other services and being able to discuss with the family the changes in cares the physician orders.
The position of case management is not the same position as skilled nursing/ respite/ hospice or palliative care. These are separate positions within the agency. The hospice case manager cannot perform other duties within the plan. The State Medicaid Agency requires a separation of who conducts the work. The person who provides case management cannot be the same person that provides direct waiver services to waiver recipients. All providers must keep service records that include the name of the person who provides the service including case management entities that also provide other HCB services. The Hospice case manager is responsible for writing and updating the plan. All changes to the plan are done in agreement with the parents and case manager- with parent or identified individual having final say. While development of the plan is being completed the identified person to complete the task is listed on the plan – this plan is reviewed and approved by the departments program manager to ensure the case manager is not completing any nursing cares or any other service listed on the plan.
Parents/caregiver and individual (when able) is required to sign off on the initial and when changes are made to the plan.
The individual providing skilled nursing/ respite/ hospice or palliative care/ other services outside of case management complete a separate billing form. The completed form outlining the services received outside of case management provided to the participant is sent to the state program manager to review and authorize the claim. The department program manager reviews the plan of care, authorizations along with the claims for payment that require the rendering provider to be listed on the claim.
The Hospice Case Manager will work with the family to develop a service plan, the family will be assisted in identifying individuals that provide informal support and know their child and family very well and formal supports they receive from agencies. The development of the service plan will be based on the guiding principles of individual and family involvement and consumer choice and control. The Service Plan will be a personalized interactive and ongoing process; to plan, develop, review and evaluate the services in accordance with the preferences and desired outcomes of the individual/ family. The service plan is reviewed at least once every three months.
The Hospice Case Manager will maximize the extent to which an individual/family participates in the service planning by 1) explaining to the individual/ family the service plan process; 2) assisting the individual/family to explore and identify their preferences, desired outcomes, goals, services, and supports that will assist them in achieving their outcomes; 3) identifying and reviewing with the individual/family issues to be discussed during service planning process This would include the ability to discuss the outcome of death and to assist the family in being able to express their concerns and feelings concerning the terminal illness; 4) giving each individual/family an opportunity to determine the location and time of Service plan meetings; participants in the Service Plan meeting, and number of meetings and length of meetings.
The family will determine who they want involved in developing the plan, but will be encouraged to include the input of their health care providers by either attending the meeting in person, by conference call or by providing recommendations in a written report. The initial service plan will be developed and will be reviewed by at least the Hospice Case Manager

and family quarterly and a new plan developed as needed. Within 5 days following a case plan meeting, the Case Manager will complete the written case plan and provide the individual/ family a copy of the plan, along with a copy to the Program Manager for authorization.

(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;
The Hospice Case Manager, family and other members of the Service plan team will review Level of Care, Letters of prognosis, current medical reports to develop a framework for the service plan. the participant service plan also addresses the need to address with the team the following areas: family, health care, safety, nutrition, financial , legal, community, mental health, education, behaviors , medications, cognition, decision making and employment .
The Hospice Case manager will complete assessment in determination of where the individual is within the multiple stages of death and complete this assessment frequently to ensure the plan is current and beneficial to the family with authorized services.

(c) how the participant is informed of the services that are available under the waiver;
A brochure has been developed describing for the family in friendly terms the types of supports available through this waiver. This brochure is shared with all families during intake and referral and again prior to the development of the initial service plan, and is available on the web.
Families are informed before they choose the Hospice agency that the case management service is within the agency of their choice by the state program manager. A family on the wavier is given their rights and responsibilities in writing upon acceptance into the program; within this information is their right to contact the state program manager to assist with any problems/ concerns they are having within the program and also information on how to contact Protection and Advocacy services if they want. Families are also given the choice of which hospice agency they would like to work with.

(d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences;
A written Service Plan will be developed by the team. Documentation will reflect the family's goals; desire to be receiving home and community based services verses institutionalization, and preferred outcomes. Informal and formal supports will be looked at to meet the family's goals and outcomes.
The participant service plan must have the parent/ individual’s signature any time there is a change to the plan and the plan must be submitted to the state program administrator to enter it into MMIS for payment. Plans are not considered valid unless the parents/ individual have signed and the state program manager has approved the plan and entered it into the MMIS system. Plans must be updated /reviewed every three months or when there is a change in need or service.

(e) how waiver and other services are coordinated;
While documenting the family's needs on the Service Plan the team will also be addressing how best to meet these needs. Team will look at waivered services, state plan options and informal options within the community and school. Services are coordinated by the hospice case manager based off of the needs identified on the participant plan of care.

f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan
The Service plan includes objectives and activities associated with the outcomes and describe specific roles and responsibilities of all parties including implementation of services and specific documentation requirements regarding delivery of services and activities performed. The Hospice Case Manager and all other services providers will review the service plan quarterly with the family to determine progress towards outcomes, satisfaction with services and to identify unmet needs. The plan identifies each individual providing a waiver service to meet the identified need, and states the case manager cannot perform any other task besides hospice case management.

(g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
A new service plan is developed as needed but no later than quarterly from the previous service plan meeting. The service plan may be amended at any time by the family and Hospice Case Manager through joint discussion, written revision and consent as shown by signature of the family. The family will have the responsibility to initiate a service plan meeting by contacting the Hospice Case Manager when the participants needs change, the service plan is not being carried out, when a change in service is desired or when a crisis develops which requires a change of plan.

The plan and progress of the plan will be monitored by the Case manager after the initial case plan has been developed. Case Manager will contact the family either by phone or in person monthly. Narrative note will document this. Case Manager will ensure that it is noted on the Service Plan that identified service will be continued under the state plan once child's possible passing is less than 6 months. There will not be any gaps in services during this transition - only funding source changes.
All Participant service plans must be sent to the state program manager for approval and to be entered within MMIS for payment. Plans are only approved if at a minimum parent/caregiver signature and hospice case manager signatures are present. All plans and claims are audited within the waiver services by the state program manager – since there are only 30 individuals per year 1005 of plans and claims are audited to ensure are within the boundaries of the waiver.
Copies of plans, documentation of notes, policy, brochures and within MMIS record of payment for rendered services are available to CMS upon request.
Due to the rural nature of ND, the state is requesting an exception for hospice case manager service to be within the hospice agency providing other services within the participant plan of care. The request is based on the specialty of the hospice case manager having the skills of being able to recognize the different stages of death, having strong communication skills in the topic of death, being available to the family at any time of need, and having access to the Hospice physician to address changes and needs. In addition, within the state of ND the only providers of hospice case management service with the above mentioned skills are within hospice agencies. There are the 22 Hospice agencies currently providing hospice service. Each agency only covers certain counties across the state http://www.ndhospice.com/locator.html . Currently; there are no other hospice case manager services available outside of the hospice agencies, but if a case manager has the skills listed within the service of case manager, that is able to enroll as a Medicaid provider the state will accept their service of hospice case manager. The independent case manager would have to meet all the requirements of the participant plan of care, and be able to ensure health welfare and safety of identified individual.

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.

With technical assistance through the state central office, the Hospice Case Manager will assess with the family, the health and safety needs of the individual. The recommendations from health care providers will be reviewed. A variety of generic community supports, as well as, formal and informal supports will be explored. The Service Plan will include emergency back-up plans to address what will happen if waiver or other support services are not available; the parents cannot carry out their role as their child's primary caregiver; or the family cannot remain in their home due to natural disasters, loss of electricity, or need to plan for obtaining special and critical items such as medication, food or equipment.

Family and team will review and discuss the possible risks to the child within the domains of family/ falls/ health care/ fire safety/ nutrition/ financial/ legal/ community/ social/ Mental Health/ education/ behaviors/ medication/ decision making cognitive and employment. If the team identifies an area of concern a goal is developed to address and diminish the risk identified on the service plan.

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.

Upon determination of eligibility to waiver, Program Manager will provide to the family a list of Hospice Agencies providers and the services they offer to choose from. When a family has questions regarding locating specialized pediatric service/ providers, the Program Manager will assist family and Hospice Case Manager, with the resources they have through Department web sites.
This list of Hospice agencies and service is provided to the family annually at time of completing of Level of Care, by the department program manager.

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):

After completion of the Service Plan by the team the Hospice Case Manager will send the plan to the Program Manager for authorization/approval of services funded through this waiver.

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):*

- [x] **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 Hospice Case Manager will be responsible to monitor the implementation of the Service Plan and the participant's health and welfare. The Service plan will be reviewed when the Hospice Case Manager meets face to face with the participant and team each quarter to review the status of identified outcomes, satisfaction with services and supports, delivery of authorized services, significant events and critical incidents related to the participant's health and safety, or any time there is a change in the health of child. Monitoring will occur every quarter minimally, option to meet more often is available at all times.

During the months there are no face-to-face visits the Hospice Case Manager will make phone contact with the family to ensure health and safety are maintained and no need for any changes to the care plan are needed.

Back up plans are listed on every care plan; due to the nature of this waiver backup plan are often the hospital or primary doctor, both are reasonable and reachable backup for the family if the Hospice agency is not responsive.

All care plans are forwarded to the program manager within three days of completion for review and approval. Program manager has three days to approve/ request follow-up the plan, and file the service auth into MMIS.
Follow up is completed monthly with the family by the case manager to ensure the plan is meeting the needs of the participant and to identify any additional problems. If at this time the case manager and family determine a problem the team is pulled together as soon as possible- to develop an alternative plan to address the problem.

All care plans are sent to the state to be reviewed - any problems are communicated by the case manager and through the care plan to the state to be monitored and looked at to identify problems or need for changes within the program.

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:*

The Hospice Case Manager is responsible for the write up of the Service Plan and the implementation of the plan, yet the development of the plan is done by the family's team- made up of legal caregiver, child, people who know family and child best and any other professional that are involved in child's care. Legal caregivers must agree with Service Plan and authorization must be given by the Program Manager prior to any payment of claims. The Department of Health & Human services - Health section has the responsibility to ensure the Hospice agency is following rules and regulation as to the care of patient. The current areas of Hospice agencies are as follows: Fargo /Grand Forks/ Lisbon/ Mayville/ Valley City/Minot/Devils Lake / Madan / Jamestown /Bismarck / Dickinson /Williston/ Rugby/ Hazen/ and Hettinger.

Parent and if possible, child sign the care plan before it is sent to the state program manager. This is how the state program manager knows the family is in agreement to the plan developed.
The case manager and other providers of waiver services sign the plan before sending it to the state program manager.
Families are given the program managers contact information and reminded annually the steps for file a grievance.
During annual Level of Care completion, the Program manager talks one on one with the family to ensure they are satisfied with the service being provided.

All case managers are required to provide written documentation of their billable service to include date/ place/ who with /what was completed and length of time to the Medicaid agency. These logs will be reviewed to ensure the Case Manager is not providing additional service to the individual outside of the scope of case management and to ensure billing is accurate.

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:
Number and percent of all waiver participants that have completed an Emergency Back-up Plan to address health and safety issues. N: Number of participants that have completed an Emergency Back-up Plan to address health and safety issues. D: Total number of participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
#&% of all Children Hospice waiver participants that have a Service Plan addressing the individual needs of the child, within 10 working days of being assigned to waiver N:Number of all Children Hospice waiver participants that have a Service Plan addressing the individual needs of the child, within 10 working days of being assigned to waiverD:total number of Children's Hospice waiver participants

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
#and % of all Children's Hospice waiver participants that have a Service Plan that have measurable/reachable goals that address the needs indicated on the intake assessment.N:number of Children's Hospice waiver participants that have a Service Plan that have measurable/reachable goals that address the needs indicated on the intake assessment.DTotal number of Children's Hospice waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
review of Service Plans.

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of all waiver participants that have services within the Service Plan to address participants medical needs. N: Number of participants that have services within the Service Plan to address participants medical needs. D: total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
review of Service Plan.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of all waiver participants that have services within the Service Plan to address participants personal goals. N: Number of waiver participants that have services within the Service Plan to address participants personal goals. D: total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
review of Service Plan.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State 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:
Number and percent of all Service Plans are updated/ revised quarterly. N: number of all Service Plans updated/ revised quarterly. D total number of service plans due for quarterly review.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of participant's service plan that are updated/ revised when warranted by changes in the participant's needs. N: total number of service plans updated/ revised due to changes in the participants needs. D: total number of service plans requiring an update or revision warranted by a change in the participants needs.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
 # & % of waiver participants that receive services from current Service Plan as specified by amount and verified by EVV data and documented logs reviewed. N: # of waiver participants that receive services from current Service Plan as specified by amount and verified by EVV data and documented logs reviewed. D: total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EVV data from aggregator and review of documentation from Hospice agency on participant cares.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # & % of waiver participants that receive services from current Service Plan as specified by type and verified by EVV data and documented logs reviewed. N:# of participants that receive services from current Service Plan as specified by type and verified by EVV data and documented logs reviewed. D: total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EVV data from aggregator and review of documentation from Hospice agency on participant cares.

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**

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

Performance Measure:
 # & % of waiver participants that receive services from current Service Plan as specified by scope of services and verified by EVV data and documented logs reviewed. N:# of participants that receive services from current Service Plan as specified by scope of services and verified by EVV data and documented logs reviewed. D: total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EVV data from aggregator and review of documentation from Hospice agency on participant cares.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # & % of waiver participants that receive services from current Service Plan as specified by duration and verified by EVV data and documented logs reviewed N:# of participants that receive services from current Service Plan as specified by duration and verified by EVV data and documented logs reviewed. D: total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EVV data from aggregator and review of documentation from Hospice agency on participant cares.

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** 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**

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

Performance Measure:
 # & % of waiver participants that receive services from current Service Plan as specified by frequency and verified by EVV data and documented logs reviewed. N:# of participants that receive services from current Service Plan as specified by frequency and verified by EVV data and documented logs reviewed. D: total number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EVV data from aggregator and review of documentation from Hospice agency on participant cares.

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

	Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/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:
Number and percent of participants given a choice of waiver services and providers. N: total number of waiver participants given a choice of waiver services and providers. D: total number of waiver participants

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

All data is held within Medical Services. The central Office Administrator and the Assistant Director of the Long Term Care Continuum meet to review data and determine if the pattern represents a systemic problem which requires more holistic solutions. If it does, then the Central Office Administrator is responsible to develop the change and to monitor the progress of change.

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 Department of Health & Human Service - Medical Service Section, Children's Hospice waiver Program Manager to address individual problems which are resolved through various methods which may include but are not limited to providing one on one technical assistance, amending policy and/or procedures. Documentation is maintained by the State that describes the remediation efforts.

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:

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

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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

The contracted entity for Level of Care determinations will notify the Central Office Administrator and the participant's parent or guardian in writing if the child did not meet the Level of Care criteria and what their rights are to request a fair hearing.

A participant requesting Children's Hospice services completes an application from. This application form contains information pertaining to consumer rights and explains the procedures clients may follow in the event they are not satisfied and wish to request a fair hearing. This form is signed and dated by the legally responsible caregiver.

The legally responsible caregiver signs the care plan indication they are in agreement with the service plan and that they have been informed of their rights to a fair hearing. The information on how to appeal a decision is also included on the Services Plan.

Participants and their family are informed that they have an opportunity to request a fair hearing when they are not given the choice to receive waiver services, and denied waiver services or providers of their choice, to their waiver services are suspended, reduced or terminated.

Families are informed of how to appeal and their rights to appeal at time of application and during care plan meetings and again if an adverse action is taken. The action includes the process and what needs to be completed to appeal the action if the family so desires. Families are informed of right to a fair hearing for a) not providing an individual the choice of home and community - based services as an alternative to institutional care b) denying an individual for the services of their choice or the provider of their choice and c) actions to deny, suspend reduce or terminate services. Case manager can assist family in writing the request, forwarding the request to the Appeals Officer if grievance is against current provider the program manager can also assist family in writing the request for an appeal hearing.

All requests for a Fair Hearing are kept in Medical Services. The process of how to make an appeal to Medical Services will be provided to families, along with authorizations. Until a decision is made services will continue, family will be notified in advance about the possible need to repay for services if appeal is denied. All outcomes of appeals will be given to families in writing.

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.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events that must be reported include: an abused child which means an individual under the age of eighteen years who is suffering from serious physical harm, or who is suffering from or was subjected to any act in violation of state criminal law definitions of coercion or deviate sexual acts towards that minor child. All instances of abuse, neglect and exploitation are a critical event and must be reported. The use of restraints is part of the definition of abuse. Therefore, case managers are also responsible to report the use of restraints or seclusion as a part of the monitoring process to assure health, welfare, and safety.

A child who is harmed which means negative changes in a child's health which occur when a person responsible for the child's welfare: inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or commits, allows to be committed or conspires to commit, against a child, a sex offense. A person responsible for the child's welfare means the child's parents, guardian or foster parent; an employee of a public or private school or nonresidential child care facility; an employee of a public or private residential home, institution, or agency or a person responsible for the child's welfare in a residential setting.

The individuals that must report critical events include: any physician, nurse, dentist, optometrist, medical examiner or coroner, or any other medical or mental health professional, religious practitioner of the healing arts, school teacher or administrator, school counselor, addiction counselor, social worker, day care center or any other child care worker, police or law enforcement officer, or member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, shall report the circumstances to the Department of Human Services or its designee, if knowledge or suspicion is derived from information received by that person in that persons official or professional capacity. A member of the clergy however is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser. (If a person has set up a special meeting to discuss issues or is stating this while in confession would be two circumstances where they could not report. If the Priest would see something in the process of an activity, educationally (quite a few Churchs have schools within their church) or a child tells them something during an activity they need to report.) Any person having reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect, may report such circumstances to the department.

Any providers of waiver services are required to report any restraint, seclusion, and restrictive interventions, criminal victimization or activity involving law enforcement, death, financial exploitation, or medication errors.'

All persons mandated or permitted to report cases of known or suspected child abuse or neglect shall immediately cause oral or written reports to be made to the department or the department designee. Oral reports must be followed by written reports within forty-eight hours if so requested by the department or the department designee. A requested written report must include information specifically sought by the department if the reporter possesses or has reasonable access to that information. Reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under the chapter in state century code

Between the ages of 19 through 21 years of age the possible abuse issues are handled through the state program Protection and Advocacy who would complete an investigation into the allegations and if need be address concerns / facts with the local police, if criminal charges are appropriate. Otherwise P& A will address needs of client and advocate for them.

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.

Through a Family Support Grant from the Administration on Developmental Disabilities, a handbook for families was developed through the North Dakota Center for Persons with Disabilities. The handbook addresses many issues related to self-directing supports. It contains a specific section regarding reporting of abuse, neglect and exploitation. This section of the handbook would be shared with the families when they consider entering the waiver, by the program manager. The family also signs a Participant Agreement that outlines the requirements to report to Child Protective Services any suspected abuse, neglect or exploitation regarding a childbirth to 18th birthday.

Annually families are provided with written information on identification of abuse, neglect, and exploitation, and how to report in writing. This is provided by the program manager at time of annual Level of Care determination. Families are provided with the website that provides free training on reporting within North Dakota - Abuse / neglect and exploitation - it is their choice to complete the training.

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.

The Child Protective Services within the Department of Human Services and its designees receive all reports of abuse, neglect or exploitation of a child. An assigned case worker will then review any and all material pertaining to the report along with personal interviews with identified individuals having any information regarding allegations. This information is given to an intra-disciplinary team of professionals who review and determine if additional services are needed. The whole process is required to begin within 24 hours of receiving the initial report as per outlined in the established state guidelines. The Central Office Administrator will follow-up with Child Protective Services regarding all reported incidents concerning status of child and resolution of investigation. The Service Plan will be modified to meet the new needs of child/ family.

The Child Protection Social Worker completing the assessment of a report of suspected child abuse or neglect shall provide notification of the case decision to the subject of the report. This notification shall be made in person. When the case decision is Services required, the notification to the subject shall be made face-to-face. If a face-to-face notification cannot be done, the reason needs to be documented. When the case decision is No Services Required, the notification may be made either face-to- face or by telephone. Out of respect for the families involved in the assessments process, the report needs to be completed as soon as possible and notification be made to families of the decision. There is not a specific time frame established.

Assessments of reports of suspected child abuse or neglect must be conducted by the department or its authorized agents in substantial conformity with the policies of the department. Assessments of reports of suspected child abuse or neglect must reflect: 1. An assessment process designed to collect sufficient information to make a decision whether child abuse or neglect is confirmed, confirmed with an unknown subject, unconfirmed, or unable to determine to provide for the protection and treatment of an abused or neglected child; 2. Assessment techniques that include interviewing and observing the subject and the child victim, interviewing other interested or affected persons, and documenting those interviews and observations; 3. Conclusions and a summary based on information gathered by assessment techniques described in subsection 2; and 4. If the child abuse or neglect decision is confirmed or confirmed within an unknown subject and the child remains at substantial risk of continued abuse or neglect due to a supported state of impending danger, development of service plans for the provision of protective services based on goals and objectives established by the department or its authorized agent for the subject and for the family of the child victim.
75-03-19-03. Time for initiating assessments - Emergencies. All nonemergency child abuse or neglect assessments must be initiated within time frames established by the department after receipt of a report by the assessing agency. In cases involving a serious threat or danger to the life or health of a child, the assessment and any appropriate protective measures must commence immediately upon receipt of a report by the assessing agency. An assessment is initiated by contact with the alleged abused or neglected child, a law enforcement officer with jurisdiction in the location where the child may be found or where the alleged abuse or neglect occurred, or the subject of the report.

75-03-19-04. Time for completing assessments. Assessments of reports of suspected child abuse or neglect must be completed, a decision made, and a written report completed and submitted to the individual designated by the department within sixty-two days from the date of receipt of the report unless an extension of the time is requested of and granted by the department.

Individual 19-21 the following pertains to:
P&A receives reports of alleged abuse, neglect and exploitation of individuals with disabilities. If there is probable cause, P&A investigates (or has another entity investigate) the allegation. When appropriate, the P&A accesses protective services on behalf of the individual. Such services may include securing a guardian or conservator, assisting the individual with finding alternative living arrangements, or assisting the individual with identifying other service options. While P&A's authority to provide protective services focuses primarily on adults, protective services may also be provided to children with disabilities when Child Protective Services has determined that the situation or incident is not within their criteria.

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.

The Department of Health & Human Service - Children and Family Services section (CFS) is responsible for overseeing the operation of the incident management system. The permanency planning philosophy cuts across all services and programs. Services are delivered in the community, if possible. The services are child centered and family focused, community driven and based and are coordinated among family service providers. North Dakota is dedicated to preserving and/or reuniting the family but not at the cost of the child's safety or well-being. The North Dakota Children and Family Service Division of the Department of Health & Human Services and the county social service agencies are committed to joint planning and collaboration with other agencies.

The State administrator of Child Protection Services: is responsible for providing direction for child protection services in North Dakota. This position encompasses preparing policies and procedures for the program and providing technical assistance to regional CPS supervisors. Abuse and neglect reports are reviewed every six months for trend/ needs. This information is used to determine need for additional services, training of staff.

County social service boards act as the departments' authorized agent for the purpose of receiving reports of suspected child abuse or neglect and conducting assessments, except as otherwise provided for by law or as otherwise determined by the department in a particular case.

Time Frames for critical incidents are as follows: After the receipt of the report, child protection services action shall occur within 24 hours if the situation is a category A (child's death) or B (criminal charges arising out of the suspected child abuse or neglect or indication from report that children are not safe and removal appears to be evident) case otherwise an initial response shall take place within 72 hours. If report involves a non-caregiver the SW shall make a referral to a law enforcement agency for disposition. All reports have a copy sent to the regional Child Protection Services Supervisor within 5 days of receiving it. This information is entered into the Child Abuse and Neglect information Index data system. For individuals within the Children's Hospice waiver the abuse and neglect registry is check every 6 months for any reports against the individual and what results came of report. If services were required, the case manager is informed and offers assistance to both the child protection team and family.

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 part of the definition of abuse. Therefore, case managers are also responsible to report the use of restraints or seclusion as a part of the monitoring process to assure health, welfare and safety. Case managers are required to review health, welfare and safety at time of completion of care plan and during any home visit.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10, and DDD-PI-006.

○ **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).

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:

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 part of the definition of abuse. Therefore, case managers are also responsible to report the use of restrictive interventions as a part of the monitoring process to assure health, welfare and safety. Case managers are required to review health, welfare and safety at time of completion of care plan and during any home visit.

Unauthorized use of restrictive interventions are required to be reported as suspected abuse, neglect, or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10, and DDD-PI-006.

○ **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.

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:

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:

For the Children involved in the Children's Hospice program the case manager is required to conduct home visits quarterly - if they observe seclusion then the team will discuss this and assist the family in positive ways of allowing the child not to be secluded. also a report of Abuse and neglect would be filed with the county designated to investigate abuse and neglect and it would be their job to determine extend of seclusion and the need for further interventions.

○ **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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

- ○ **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.

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:
Number and percent of reports of incidents of abuse, neglect, exploitation and unexplained death that are reported within the required timeframe. N: Number of reports of incidents of abuse, neglect, exploitation and unexplained death that are reported within the required timeframe. D: total number of reports of incidents of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(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** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of unexplained deaths where follow-up addressing and seeking to prevent has occurred for waiver participants. N: total number of unexplained deaths where follow-up addressing and seeking to prevent has occurred for waiver participants. D: total number of unexplained waiver participant's deaths.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of reports where abuse, neglect or exploitation is substantiated, where follow-up is completed on recommendations for waiver service providers. N: Number of reports where abuse, neglect or exploitation is substantiated, where follow-up is completed on recommendations for waiver service providers. D:Total number of reports where abuse, neglect or exploitation is substantiated

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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**

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

Performance Measure:
Number and percent of incidents of abuse, neglect, exploitation and unexplained death that is reviewed/investigated within the required timeframe. N: Number of incidents of abuse, neglect, exploitation and unexplained death that is reviewed/investigated within the required timeframe. D total number of incidents of abuse, neglect, exploitation and unexplained death that are reviewed/investigated.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
#&%of Children's Hospice participants legal caregiver that report receiving information about how to identify and report incidents of abuse/neglect and exploitation.N:Number of Children's Hospice participants legal caregiver that report receiving information about how to identify and report incidents of abuse/neglect and exploitation.Dtotal number of Children's Hospice participants legal caregiver

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents where the root cause was identified. N: number of critical incidents where root cause was identified. D Total number of critical incidents.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incident trends where systemic interventions were implemented. N: number of critical incident trends where systemic interventions were implemented. D: number of critical incidents trends.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **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:

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:
Number and percent of reported complaints regarding restraints and seclusion that were substantiated through investigation, where follow-up is completed as required. N: Number of reported complaints regarding restraints and seclusion that were substantiated through investigation, where follow-up is completed as required. D: Total number of substantiated restraint and seclusion complaints reported.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number & Percent of providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion. N: number of providers with policies and procedures in place that prohibit the use of restrictive interventions, including restraints and seclusion. D: total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
provider policy 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** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
Number & Percent of providers with training requirements on the use of alternative measures in lieu of restrictive interventions, including restraints and seclusion. N: number of providers with training requirements on the use of alternative measures in lieu of restrictive interventions, including restraints and seclusion. D: Total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
review of provider training records

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: 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:
Number and percent of participants, who have a yearly EPSDT screening completed by either their primary care provider or Health Tracks. N: Number of participants, who have a yearly EPSDT screening completed by either their primary care provider or Health Tracks D: total number of waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
 # & % of waiver participants that have an initial EPSDT screening completed at time of enrollment into the Children's Hospice waiver. N: total number waiver participants that have an initial EPSDT screening completed at time of enrollment into the Children's Hospice waiver. D: total number of waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
documentation of visit.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Hospice Case Manager will address recommendations, from completed investigation, with caregivers and develop a plan of action with the assistance of the child's Hospice team to prevent further abuse/neglect. This plan will be recorded on the Service Plan and monitored as needed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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.

Appendix H: Quality Improvement Strategy (2 of 3)

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 State is responsible for evaluating the effectiveness and outcomes of the discovery, remediation and quality improvement plans. The State prioritizes its remediation efforts to address safety and welfare of client first. In addition, abuse neglect and exploitation is defined in the NDCC 25-01.301.This explanation is shared with families upon enrollment into the program and family signs a Participant Agreement that outlines the requirements to report to Child Protective Services any suspected abuse, neglect or exploitation to a child between the ages of birth to 18.
Requirements for 19-21 year olds are found under NDCC 25-01.3-01

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**

Responsible Party*(check each that applies):*	Frequency of Monitoring and Analysis*(check each that applies):*
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: ongoing as needed

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.

System design changes are monitored by the Program Manager and discussed with the LTC Program Administrator at monthly meetings. The Program Manager keeps track of identified problems, the system change to address problems, and if the system change resolved the issue. If no resolution to the problem occurs, the issue is readdressed by the Program Manager and LTC Program Administrator.

Input will be obtained from outside participants when appropriate. These participants might be Hospice Association, parents, nurses/counselors or participants.

In the MMIS system there will be built-in edits that ensure state plan is used first. Program manager will monitor this to ensure. The exception to this edit would be skilled respite in Home Health Aide. There will be edits to ensure only the authorized service on the plan is able to be billed and only one service of HHA, Skilled Nursing or Palliative at a time. State will monitor to ensure State plan is utilized first along with built in edits into the MMIS system to assist with this. Work orders for these edits are being developed and prioritized!

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

System changes and common errors or individual problems that have been identified via the audit process are discussed by the Program Manager and LTC Program Administrator. Input from Hospice Agencies involved in caring for children will be compared to the assurances. Positive areas and problem areas will be identified and shared with the Hospice Case Managers, annually. System changes or training will be completed to address problem areas.

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).*

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 to include claims payment and accuracy of claims for FFP. The waiver is part of this audit annually.

An agency audit of the Department of Health & 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. Random sampling of individuals receiving Medicaid – the State Auditor determines the sample.

In addition, 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.

For biennial agency audits, the NDCC gives the State Auditor the responsibility to determine the contents of audit reports. In the year 2000, with the needs of our stakeholders in mind, the Office of the State Auditor changed from following financial statement audit standards to following the performance audit standards contained in Government Auditing Standards, issued by the Comptroller General of the United States.

The state does not require providers to secure an independent audit of their financial statements. The verification of all the provider qualifications is completed within the MMIS system and oversight completed by the provider enrollment division of Medicaid.

The Program manager completes desk audits of all enrolled providers on an annual basis to determine if operational and administrative functions have been carried out. this audit includes the review of Children Hospice waiver individuals paid claims to determine if activities and task were billed/paid with in allowable limits. sample size is 100% of waiver participants. All audits are desk reviews.
Process for assurances of correct billing and not errors are as follows. Claims come in from provider, claims match up against authorization within MMIS, and is approved for payment. Claim is paid. Financial department assures the claim is paid correctly and the money is taken out of designated waiver, and that identified child is within the waiver. State Program Manager, reviews claims every 6 months to identify problems and corrections needed.

Family and team develop a service plan and authorization form for waiver services to address identified child's needs. The authorization is entered into MMIS by the State Program Manager. Once a request comes into the MMIS system for a waivered service it is checked against the authorization to ensure payment is agreed upon. Payment is made. This information is reported to CMS as scheduled.

In addition, the Program Manager ensures the Authorization is followed and that payment for waiver service is completed correctly and that provider of service has been paid, within the MMIS system. This occurs quarterly.

The State Program Manager reviews all payments made on behalf of waiver participants every three months and compare them to the authorization to ensure the waiver service has been authorized during time of payment. If discrepancies are noted, then payment is recouped from the provider of service.

The Program Manager reviews 100% of participants - all waiver claims are reviewed to include care plan, authorization, claim submitted to MMIS, EVV verifications and payment. these are all desk audits, recoupment of claims when determined to be completed in error are submitted through MMIS. Providers are informed of results of audit and correction actions in writing and have the option to requests a review of findings in person. For audits of the Children ‘s hospice waiver these are desk reviews of every individual involved in the Children’s Hospice waiver. Results are communicated in writing with option to discuss in person at provider's request. Corrective action plans are required if errors are found. The reviewer is responsible to follow up with all corrective actions to assure compliance before the review can be closed. Corrective action plans may include a requirement that a provider with a history of billing errors will audit again in the near future to assure compliance.

Corrective action plans are required if errors are found. The reviewer is responsible to follow up with all corrective actions to assure compliance before the review can be closed. Corrective action plans may include a requirement that a provider with a history of billing errors will audit again in the near future to assure compliance. Inappropriate claims are recouped/

adjusted through the MMIS system either by requested adjustment of future payments or in option of repayment from the provider in a lump sum. Claims department is then requested to manually enter an adjustment to reflect the corrected billing error in MMIS.

Electronic Visit Verification (EVV) is used for Respite service under PCS and for Skilled Nursing, Hospice, and Palliative Care services under HHCS. EVV is used to verify service within the home and for claim verification.
Corrections to claims are made by making an adjustment in MMIS system to the claim followed by this information being reported on the CMS 64 report.

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:
Number and percent of all MMIS billings concerning Children's Hospice waiver participants services that match authorizations. N: number of MMIS billings concerning Children's Hospice waiver participants services that match authorizations. D: Total number of mmis billings for Children's Hospice.

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***

☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Financial audits
If 'Other' is selected, specify:

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

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver service authorizations that are accurately completed when compared to care plan. N Number of waiver service authorizations that are accurately completed when compared to care plan. D: total number of waiver service authorizations.

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for	***Frequency of data***	***Sampling Approach****(check*

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N: Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. D: total number of claims.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Children's Hospice waiver claims paid only for services rendered. N: Number of Children's Hospice waiver claims paid only for services rendered. D: total number of Children's Hospice waiver claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims for Children's Hospice waiver services.

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence*

		Interval =
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Number and percent of payment rates that are consistent with the rate methodology in the approved waiver. N: number of payment rates that are consistent with the rate methodology in the approved waiver. D: total number of payment rates.

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the 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 Department of Health & Human Service - Medical Service Section, Children's Hospice waiver Program Manager to address individual problems which are resolved through various methods which may include but are not limited to providing one on one technical assistance, amending policy and/or procedures. Documentation is maintained by the State that describes the remediation efforts.

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***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Initial rates were established by using the methodology below per service– this information has been left within the waiver to explain the original rates since there has been no consistent usage of rates to determine effectiveness of rates. Since the original rates were set waiver rates have been reviewed biannually when the Department's budget is prepared. Rates may be increased by Legislature appropriations. The Legislature may or may not grant an inflationary increase during the session which is every two years. Testimony from stockholders is encouraged during Legislation Budget hearings and Interim Human Service Committee Hearings. Providers are able to give testimony regarding rates.
Case Management- was based on the rates within the human service centers established for case management services within other programs.
Respite – was compared to the Fee for Service rates paid within Home Health rates per quarter to determine rate since this was a similar service.
Hospice – This is a nursing task and therefore the rate was set by looking at nursing rates/ comparative tasks already established within the Fee for Service system of Medicaid.
Skilled Nursing - This is a nursing task and therefore the rate was set by looking at nursing rates/ comparative tasks already established within the Fee for Service system of Medicaid.
Bereavement counseling - Rates for comparative services within the human service centers were utilized to establish this rate.
Equipment and supplies – This service was built using comparative rates from the Medically Fragile approved rates.
Expressive therapy – The rate was set by this comparing service to the rate of Individual therapy through the Human Service Centers.
Palliative - This is a nursing task and therefore the rate was set by looking at nursing rates/ comparative tasks already established within the Fee for Service system of Medicaid.

All rates are reviewed by the fiscal department to ensure the rate was sufficient and comparable to ensure providers would enroll and that the quality of care would be provided for this renewal. These rates are reviewed every time the waiver is approved or when Legislation appropriates funds.
• Note: during the 2017 Legislative session there were no increases to rates appropriated. In light of this past action the current estimated rates have remained the same for year one and increased by 3% per year for years 2-5. All service rates are the same rate for every provider.
Opportunity for public comment on waiver services/ rates has been made available on a quarterly schedule through the Medicaid Advisory Committee. Also the waiver has been posted on the web/ public notice was posted within the major newspaper.
Public comments are solicited concerning rate changes during the public notice of the waiver being submitted as outlined in Main Section 6-I of this application. At that time, they may make comments by email/ calling or in writing to the department. All comments are public and shared upon request. The public also has the opportunity to testify during Legislation Budget hearings and Interim Human Service Committee Hearings.
Payment rates are made available to the waiver participants through the care plan and through public comment within the public notices provided within newspapers and the web. Rates are also posted on Fee Schedule posted on the web within the posted waiver, codes and limits are stated on the service plan. All rates are the same across the state - there is no differentiations. Rates are reviewed biannually when the DHS budget is prepared. The sufficiency of a rate is determined based on the number of clients who are able to access services including access in rural areas. For the Children's Hospice waiver Hospice agency are encouraged to make comment on the rates during the open comment period.
All service plans are reviewed and approved by State Program Manager. The information from the service plan is used to create an authorization to provide services that is given to the provider before services begin. It lists the type, amount, duration, and frequency of the services the provider is authorized to provider to the participant. In addition, the information from the approved plan is used to create a service authorization (SA) in MMIS for all waiver services being authorized. The SA within MMIS also states the type, amount, and duration of the services authorized. When claims are submitted the claims data is checked against the SA for accuracy. If the claims is billed within the authorized limits it pays, if not, it denies.
2022 the Dept. of Health & Human Service – Fiscal section reviewed/rebased the rates and determined year five was approp. rates for this renewal. These rates were also utilized in 2022 to develop/build the department's budget for the legislation session of 2023. rates are reviewed every two years - last rebased was 2022.
The department of Health & Human Services - Fiscal Section is responsible for rate determination and oversight. this is conducted by comparison to similar services within the department and adjustment to rates during budget building process for legislation sessions this occurs every two years. Fiscal Section reviews claims and reports expenditures on the 64 reports. Program manager oversees and conducts audits to ensure correct rates are being utilized on claims.
link to the Children's Hospice waiver: https://www.hhs.nd.gov/sites/www/files/documents/draft-childrens-hospice-waiver-

7-1-2023.pdf

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:*

The flow of billing for waiver services will be provider directly billing MMIS system. Services that are billed to the waiver are only services that have been approved on the care plan and provided to the family. The care plans reflect the progress of the plan with updates and narratives – for the post grief counseling - if family chooses to use this service then an audit of the care plans and documentation from the Hospice Agency will be completed by the Program Manager 6 months after the passing of child. Once child reaches 6 months or less of life expectancy then the services of case management, Home Health Aide, Hospice, Skilled Nursing and Palliative services will be billed to the state plan instead of waiver. This will be reflected on the Service authorizations that are entered into MMIS.
Audit would include the review of documentation from the agency to include case management, counselors and nursing staff to verify the services were provided.
Electronic Visit Verification (EVV) is used for Respite service under PCS and for Skilled Nursing, Hospice, and Palliative Care services under HHCS. EVV data is verified by the aggregator and submitted to MMIS through standard 278 transactions to verify the visit against the benefit plan, service auth and submitted claim within MMIS before payment occurs. Corrections to claims are made by making an adjustment in MMIS system to the claim followed by this information being reported on the CMS 64 report.

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:*

The Medicaid payment system will only pay claims if the individual is an approved Medicaid recipient; has a valid Level of Care has a secondary confirmation letter from a Hospice Physician and a current Service Plan that includes a service authorization for the waiver services. In addition, when a claim is submitted to MMIS the dates of service for Respite, Skilled Nursing, Hospice or Palliative Care are verified by EVV data.
The claim will deny if the individual is not Medicaid eligible or does not have a service plan in place or there is not EVV verified visit. Documentation from provider will be provided to Medical Services upon request.

EVV is required for skilled nursing, hospice, palliative care, and respite services. The state has an open model- providers may choose to use their own EVV system and will be required to submit data to a data aggregator. Edits and exceptions to the EVV visit are handled by the Provider administrator to manually update a visit when necessary – the manual correction is tracked in the systems and may be subject to audits.

Rendered services that have been billed to the waiver are only paid if the services have been approved on the care plan, entered on a service authorization that states type, amount, duration, and frequency of the services the provider is authorized to provider to the participant within MMIS and verified through the EVV process (standard 278 transaction) – for the post grief counseling - if family chooses to use this service then an audit of the care plans and documentation from the Hospice Agency will be completed by the Program Manager 6 months after the passing of child.
Only claims that are not subject to EVV may be billed inappropriately since they are not verified through the EVV data system checks. These inappropriate claims would be discovered through the program managers audit of the individuals claims. All inappropriate claims will be adjudicated through the MMIS system and fund recouped from future payments or in a full payment from the provider if no longer providing the services.
To include a description of how payments for inappropriate billings are recouped. Only claims that are not subject to EVV may be billed inappropriately since they are not verified through the EVV data system checks. These inappropriate claims would be discovered through the program managers audit of the individuals claims. All inappropriate claims will be adjudicated through the MMIS system and fund recouped from future payments or in a full payment from the provider if no longer providing the services. Corrections to claims are made by making an adjustment in MMIS system to the claim followed by this information being reported on the CMS 64 report.

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:

☐ ***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:

Human Service Centers for the completion of Expressive Therapy.

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.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:*

- ☒ ***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:*

Do not complete this item.

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: Nursing Facility

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	36203.29	26314.00	62517.29	122027.00	106574.00	228601.00	166083.71
2	37286.26	27103.42	64389.68	125687.81	109771.22	235459.03	171069.35
3	38405.64	27916.52	66322.16	129458.44	113064.36	242522.80	176200.64
4	39556.60	28754.01	68310.61	133342.20	116456.28	249798.48	181487.87
5	40745.41	29616.63	70362.04	137342.47	119949.98	257292.45	186930.41

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:
		Nursing Facility
Year 1	30	30

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:
		Nursing Facility
Year 2	30	30
Year 3	30	30
Year 4	30	30
Year 5	30	30

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.*

During the three years of accepted 372 reports dated 2019, 2020 and 2021 there were 4 participants who were served. This resulted in a total of 339 days of service. The average length of stay for an individual based on this information was 85 days.

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:*

Rates and average cost for year one was determined by review of rates for year 2022-2023 of current waiver services rates compared to 2023 service rates within Home Health Services within state plan and Regional Human Service Centers during the 2023 budget. During the legislation session of 2023, which ended on April 30, 2023 - providers were given an increase of 3% for fiscal year 2024 and 2025 (WY's 2-3) and it has been determined it is appropriate to anticipate the same 3% increase for the remaining WY's of 4-5.
Number of user, and average units per user remain an estimate based on utilization of services from past participants and examples from Children Hospice International Program for All -inclusive Care (Chi PACC) information. Trends of utilized services and authorized units were reviewed from the start of the Children's Hospice waiver in 2010 to assist in the determination of estimated units for services.

All rates were reviewed by the Department of Health & Human Services - fiscal section. The last review was in 2022 to ensure the rate are sufficient and comparable to ensure providers would enroll and that the quality of care would be provided for this renewal, and to build the 2023-2025 legislation budget.

For EVV programming purposes this service is moving from a hour unit rate to a 15 min unit rate. The hour rate was 58.05 breaking this down to a 15 min unit rate make is $14.52 per 15 min.

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:*

When estimating the Factor D' it was determined the most similar population group for Nursing Facility Level of Care estimates would be Aged and Disabled Home and Community Based Services. Factor D' expenditures were taken from the approved annual report for the Home and Community Services (372 HCBS waiver report dated 2021). During the legislation session of 2023, which ended on April 30, 2023 - providers were given an increase of 3% for fiscal year 2024 and 2025 (WY's 2-3) and it has been determined it is appropriate to anticipate the same 3% increase for the remaining WY's of 4-5. Since there are no dual eligible participants within the sample population there was no amount to be accounted or removed for the service of prescribed drugs purchased through Medicare Part D.
Factor G' is based on the Nursing Home costs which are of a higher medical focus to include costs that if the child is home, would not occur – ie. Medical appointments and monitoring of appointments. These costs are covered by the parent when the child is in the home. Therefore, the cost of being home with medical issues is less than being in a nursing home.

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:*

Medical Assistance Spend-down report dated September 2022 was used to calculate the G factor. The G factor is based on the current average cost for nursing facility services for those individuals eligible for the HCBS waiver minus the average nursing home recipient liability (cost share). A 3% increase was applied for years 2-5, as this was granted through 2023 legislation process.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Medical Assistance Spend-down financial report was used to calculate G', the average cost of other Medicaid services. This figure does not include the cost of prescribed drugs furnished to dual eligible under Medicare Part D. Since there are no dual eligible participants within the sample population there was no amount to be accounted or removed for the service of prescribed drugs purchased through Medicare Part D. A 3% increase was applied for years 2-5, as this was granted through 2023 legislation process.
Factor G' is based on the Nursing Home costs which are of a higher medical focus to include costs that if the child is home, would not occur – ie. Medical appointments and monitoring of appointments. These costs are covered by the parent when the child is in the home. Therefore the cost of being home with medical issues is less than being in a nursing home.

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	
Case Management	
Respite	
Hospice	
Skilled Nursing	
Bereavement Counseling	
Equipment and supplies	
Expressive Therapy	
Palliative	

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*
Case Management Total:						***37428.00***
Case Management	*15 minutes*	*30*	*40.00*	*31.19*	***37428.00***	
Respite Total:						***128356.80***
Respite	*15 minutes*	*17*	*520.00*	*14.52*	***128356.80***	
Hospice Total:						***392296.20***
Hospice	*daily*	*30*	*74.00*	*176.71*	***392296.20***	
Skilled Nursing Total:						***90372.48***
Skilled Nursing	*15 minutes*	*8*	*778.00*	*14.52*	***90372.48***	
Bereavement Counseling Total:						***301938.00***
Bereavement Counseling	*hour*	*30*	*98.00*	*102.70*	***301938.00***	
Equipment and supplies Total:						***10281.80***
Equipment and supplies	*item*	*5*	*1.00*	*2056.36*	***10281.80***	
Expressive Therapy Total:						***119152.80***
Expressive Therapy	*hour*	*30*	*39.00*	*101.84*	***119152.80***	
Palliative Total:						***6272.64***
Palliative	*15 min*	*2*	*216.00*	*14.52*	***6272.64***	

GRAND TOTAL:	***1086098.72***
Total Estimated Unduplicated Participants:	***30***
Factor D (Divide total by number of participants):	***36203.29***
Average Length of Stay on the Waiver:	*85*

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*
Case Management Total:						***38544.00***
Case Management	*15 minutes*	*30*	*40.00*	*32.12*	***38544.00***	
Respite Total:						***132158.00***
Respite	*15 minutes*	*17*	*520.00*	*14.95*	***132158.00***	
Hospice Total:						***404062.20***
Hospice	*daily*	*30*	*74.00*	*182.01*	***404062.20***	
Skilled Nursing Total:						***93048.80***
Skilled Nursing	*15 minutes*	*8*	*778.00*	*14.95*	***93048.80***	
Bereavement Counseling Total:						***310993.20***
Bereavement Counseling	*hour*	*30*	*98.00*	*105.78*	***310993.20***	
Equipment and supplies Total:						***10590.25***
Equipment and supplies	*item*	*5*	*1.00*	*2118.05*	***10590.25***	
Expressive Therapy Total:						***122733.00***
Expressive Therapy	*hour*	*30*	*39.00*	*104.90*	***122733.00***	
Palliative Total:						***6458.40***
Palliative	*15 minutes*	*2*	*216.00*	*14.95*	***6458.40***	
				GRAND TOTAL:		***1118587.85***
				Total Estimated Unduplicated Participants:		***30***
				Factor D (Divide total by number of participants):		***37286.26***
				Average Length of Stay on the Waiver:		*85*

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
Case Management Total:						**39708.00**
Case Management	15 minutes	30	40.00	33.09	**39708.00**	
Respite Total:						**136136.00**
Respite	15 minutes	17	520.00	15.40	**136136.00**	
Hospice Total:						**416183.40**
Hospice	daily	30	74.00	187.47	**416183.40**	
Skilled Nursing Total:						**95849.60**
Skilled Nursing	15 minutes	8	778.00	15.40	**95849.60**	
Bereavement Counseling Total:						**320313.00**
Bereavement Counseling	hour	30	98.00	108.95	**320313.00**	
Equipment and supplies Total:						**10907.95**
Equipment and supplies	item	5	1.00	2181.59	**10907.95**	
Expressive Therapy Total:						**126418.50**
Expressive Therapy	hour	30	39.00	108.05	**126418.50**	
Palliative Total:						**6652.80**
Palliative	15 min	2	216.00	15.40	**6652.80**	

GRAND TOTAL:	**1152169.25**
Total Estimated Unduplicated Participants:	**30**
Factor D (Divide total by number of participants):	**38405.64**
Average Length of Stay on the Waiver:	85

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
Case Management Total:						**40896.00**
Case Management	15 minutes	30	40.00	34.08	**40896.00**	
Respite Total:						**140202.40**
Respite	15 minutes	17	520.00	15.86	**140202.40**	
Hospice Total:						**428659.80**
Hospice	daily	30	74.00	193.09	**428659.80**	
Skilled Nursing Total:						**98712.64**
Skilled Nursing	15 minutes	8	778.00	15.86	**98712.64**	
Bereavement Counseling Total:						**329926.80**
Bereavement Counseling	hour	30	98.00	112.22	**329926.80**	
Equipment and supplies Total:						**11235.20**
Equipment and supplies	item	5	1.00	2247.04	**11235.20**	
Expressive Therapy Total:						**130209.30**
Expressive Therapy	hour	30	39.00	111.29	**130209.30**	
Palliative Total:						**6855.84**
Palliative	15 min	2	216.00	15.87	**6855.84**	

GRAND TOTAL:	**1186697.98**
Total Estimated Unduplicated Participants:	**30**
Factor D (Divide total by number of participants):	**39556.60**
Average Length of Stay on the Waiver:	85

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
Case Management Total:						**42120.00**
Case Management	15 minutes	30	40.00	35.10	**42120.00**	
Respite Total:						**144445.60**
Respite	15 minutes	17	520.00	16.34	**144445.60**	
Hospice Total:						**441513.60**
Hospice	daily	30	74.00	198.88	**441513.60**	
Skilled Nursing Total:						**101700.16**
Skilled Nursing	15 minutes	8	778.00	16.34	**101700.16**	
Bereavement Counseling Total:						**339834.60**
Bereavement Counseling	hour	30	98.00	115.59	**339834.60**	
Equipment and supplies Total:						**11572.25**
Equipment and supplies	item	5	1.00	2314.45	**11572.25**	
Expressive Therapy Total:						**134117.10**
Expressive Therapy	hour	30	39.00	114.63	**134117.10**	
Palliative Total:						**7058.88**
Palliative	15 min	2	216.00	16.34	**7058.88**	

GRAND TOTAL:	**1222362.19**
Total Estimated Unduplicated Participants:	**30**
Factor D (Divide total by number of participants):	**40745.41**
Average Length of Stay on the Waiver:	85