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Subject: Deliverable 2.1.2. Authorization Processes for North Dakota HCBS Waivers

1915(i) State Plan Amendment Authorization Process

An eligibility application (SFN 741) must be submitted to a Human Service Zone. There a case manager reviews eligibility criteria. To be approved, applicants must:

- Be currently enrolled in ND Medicaid or Medicaid Expansion; and
- Have a household income at or below 150% of the Federal Poverty Level; and
- Have a qualifying behavioral health diagnosis; and
- Receive a WHODAS score of 25 or above; and
- Not reside in an institution.

The application must be completed with all applicable information about the individual and include signatures of either the applicant, their legal guardian or parent. Additionally, an official diagnosis completed by a medical professional must be present including the ICD-10 code(s) along with contact details for the diagnosing professional. Applicants must be diagnosed with one or more qualifying ICD-10 diagnoses codes approved for this waiver. Finally, the WHODAS is completed by a 1915(i) Qualified WHODAS Administrator. When the application is fully completed, it can be provided to the Human Service Zone via mail, email, fax, or in person for eligibility determination.

Upon receipt of the application, the 1915(i) Eligibility Worker will sign and date the application and complete the eligibility determination no later than five business days from receipt of the completed application. The applicant, legal guardian, or parent will receive an approval or denial letter from the Human Service Zone informing them of their eligibility determination.

Personal Care Services State Plan Authorization process

Prior authorization by a case manager is required for all personal care tasks provided to an individual who meets the qualifying criteria for personal care services. The case manager must complete Personal Care Services Plan SFN 662 authorizing the services and hours that may be provided per month. Services and hours may be authorized for a period not to exceed 6 months.

The case manager must submit SFN 662 and supporting SFN 663(s) to either Aging Services or the Developmental Disabilities Division within three (3) working days of the date of completion of an assessment. Payment by the state for personal care services may not be made without a prior authorization. Except for the authorization of Personal Care Services to be provided in a basic care facility, Personal Care Services may not be authorized prior to the date of the assessment. Authorization of Personal Care Services in a basic care facility may be authorized for up to 10 working days prior to the date of the assessment.

In addition, prior authorization from a State HCBS or DD Program Administrator is required to authorize units for meal prep, laundry, shopping, and housekeeping when performed by a live-in provider or for a client who lives with other capable persons. Authorizations must be renewed annually.

The authorization period may not exceed six (6) months or three (3) months for Level C Personal Care, except for an initial authorization which can include a partial month for slightly more than six (6) months. Renewal of the authorization should coincide with the six (6) month review or annual reassessment. The authorization period should begin on the first of the month, except if this is an initial authorization for personal care services for an individual or if a change in status or provider occurs, and must end on the last day of a month. Authorized units must be supported by documentation in the individual's case file. The case manager must sign and date the form to officially authorize, reauthorize, or cancel the Personal Care Services.

Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver (0037.R08.00)

Authorization processes for this waiver are dependent on services required to meet recipient needs. A variety of services are offered under this waiver since severity and acuity of needs vary by recipient.

Residential Habilitation, Independent Habilitation, Day Habilitation, Prevocational Services, Individual Employment, Small Group Employment, and Intermediate Care Facilities

The assessment score will be multiplied by a formula based on the selected service. This will provide the team with the number of service hours per month. If the team determines that the assessment score hours are not adequate for the individual, the team will need to review the outlier policy. If the individual meets the criteria in the policy, the team will need to complete the outlier request form (SFN 1835). The regional Developmental Disabilities (DD) Program Administrator (DDPA) will review the outlier request and forward it to the DD Division for final review. The DD Division will review all outlier requests and communicate its final decision to the DDPA who will inform the team of the decision.

In-Home Supports, Parenting Supports, Extended Home Health Care (EHHC)

The Developmental Disabilities Program Manager (DDPM) uses a service application form instead of the assessment tool to determine the amount and frequency of these services, not to exceed the limits established in the Traditional Waiver. The individual, family, and DDPM will complete the In-Home Support Application annually which may include information on the client's behavioral status, stress upon the family, and type and frequency of service required.

Community Transition Services

The individual, family, and DDPM will complete the Transitional Budget Form (SFN 1862) with necessary signatures. The Regional Staff will submit the form to the DD State Office for prior approval. This form serves as the pre-authorization for this service.

Self-Directed Supports

Clients have budget authority (authority to direct allotted funds) for all self-directed service options. Their financial management responsibilities include scheduling services, requiring additional staff qualifications, recommending a service provider, substituting staff members, authorizing payments for goods and services, reviewing and approving provider invoices for services rendered, and determining staff wages. Clients are free to select a wage rate above the wage limits established by the State, but they may not reallocate funds assigned to each service. To assist with financial management, each client is assigned a fiscal agent.

Adult Foster Care (AFC) and Homemaker

The authorized units for these services will be based on the assessed needs of the individual, the time frame in which the service can be provided, the maximum amount of service authorized, the tasks the Qualified Service Provider (QSP) is authorized to provide, and the global and client-specific endorsements required of the QSP. If a service is provided by multiple QSPs who meet the required endorsements, only one SFN 1810 detailing each provider's share of service units should be completed.

1915(c) Children's Hospice (0834.R02.00)

This waiver removes the requirement of a physician certification that death is expected within six months and allows the family to provide treatments both curative and palliative for the child from time of diagnosis to death. A diagnosis of less than one year to live is required. The ages of eligible service recipients are between birth and 22 years. The initial application is submitted to Medical Services with the Level of Care (LOC) completed by the program manager. Following that, the family identifies the hospice program of their choice including the hospice physician who confirms the diagnosis. The hospice case manager sets up a meeting, oversees development of the service plan, and ensures implementation including sending the plan to Medical Services for authorization.

The LOC instrument used by the State is entitled Level of Care Determination form. The completed document must be approved by the contract entity, Dual Diagnosis Management (DDM), screening team to support that the individual meets the nursing facility LOC as defined in North Dakota Administrative Code (N.D.A.C.) 75-02-02-09. DDM forwards a copy of the determination response to the program manager. This process is required for initial and re-evaluation of LOC when the child is in the program.

1915(c) Autism Spectrum Disorder (ASD) Birth through Fifteen (0842.R02.00)

The Autism Spectrum Disorder (ASD) waiver serves children ages birth to fifteen. Families of children those ages who are diagnosed with ASD and have a gross family income up to 200% of the Federal Poverty Level (FPL) and do not receive services through another waiver may qualify for the ASD voucher program. The program provides up to $7,500 per year to help families with the cost of supporting a child with autism in need of assistive technology, training, and other support services that enhance the quality of life of children with ASD and help meet the unique needs of their families. The authorization process includes diagnosis of ASD, proof of residency in North Dakota and verification of financial

eligibility. The voucher year is July 1st through June 30th. Approved voucher requests must be initiated within the first 60 days after approval, or they will no longer be available.

In the budget determination process, an authorization document is developed listing the amount and type of service and the overall budget. When that document is approved by the Program Administrator, information is entered into the eligibility file which authorizes services and overall budget. The authorization document is then forwarded to the fiscal agent where payment limits are established in their payment systems.

There are currently 66 children on the waiting list for this waiver.

Medicaid Waiver for Medically Fragile Children (0568.R03.00)

A child must be Medicaid eligible, must pass the Nursing Home Level of Care (LOC), and receive a minimum score on the Level of Need Criteria with Family Viewpoint. Families also must have a need for a waiver service not including case management. A Level of Need determination score would be obtained from a primary physician for children who have passed the LOC. This form will be scored by the primary physician of the child and would look at care elements within the following areas: overall care, skin/physical management, metabolic, GI/feeding, urinary/kidney, neurological, respiratory, and vascular. The family viewpoint is completed by the family and may cover: daily schedule, areas child needs assistance (e.g. dressing, eating), out of home doctor-therapy sessions per day, list of daily medications (including how they are administered), how often doctors are called during the day, and how many visits to the ER are required due to the child's conditions. They go on to ask about the number of children in the home, any special needs of other children, parents work schedule, supports within the home, and any other important details regarding the care of child and family. Higher scores indicate the child has more needs. The child with the highest score will be placed on top of the waiting list. The program manager or case manager will work with the family in the development of the person-centered plan of care and the individualized waiver authorization. Finally, once the authorization is approved through the Central Office, the family may begin to work with the fiscal agent to complete the process of hiring their employees or selecting vendors for the service authorization.

A program manager or a case manager will facilitate the development of a transition plan within the case plan by the time the child is 17 and a half years of age. Examples of support options that may be considered include: Medicaid State Plan Services, other Waivers, nursing facilities, vocational rehabilitation,1915i services, etc.

There are currently ten (10) children on the waiting list for this waiver.

Authorization Processes for Medicaid Waiver for Home and Community Based Services (0273.R06.00); Personal Care Services State Plan; Service Payment to the Elderly and Disabled (SPED) and Expanded Service Payment to the Elderly and Disabled (Ex-SPED)

Referrals for SPED, Ex-SPED, HCBS Medicaid waiver and Medicaid State Plan-personal care come in through North Dakota's Aging and Disability Resource Link (ADRL or no wrong door/single point of entry). When the referral is received, an Intake Specialist from the ADRL will complete the intake assessment via the phone or reach out to the applicant within three business days if the referral is

submitted via the web. The intake process helps determine referral options including information necessary to formally refer an individual to an HCBS case manager. ADRL intake specialists do not determine eligibility and individuals can request a home visit even when the information provided during intake makes it seem as though they do not meet eligibility requirements.

The Aging Division receives the intake information and assigns a case manager to conduct an in-person HCBS Comprehensive Assessment and determine program eligibility. The assessment includes some participant information in terms of demographics, if there are legal decision makers or other supports, who they have as caregivers, and information on behavioral health supports needed. The case manager learns about what medical conditions are contributing to their medical disabilities. They also inquire about any services the individual already receives. A functional assessment is performed (ADL and IADL) using the Barthel Index, which is appropriate for individuals 18 years and older. The HCBS Comprehensive Assessment enables the HCBS case manager to record the individual's functional impairment level and correlate that to the need for in-home and community-based services.

Individuals must actively participate in the functional assessment to the best of their ability. Case managers must document in the narrative if there is a medical reason why the individual cannot participate in the assessment or answer questions directly. If a third party (including family) reports that the individual cannot participate in the assessment, but the case manager questions if this information is accurate, the case manager may request medical documentation to confirm that the individual is not capable of participating before eligibility can be established.

It is the responsibility of the individual to provide all information necessary to establish eligibility per NDAC 75-03-23-15. Proof of blindness, disability, and functional limitation may include, but is not limited to, complying with all requests for medical records or an evaluation, such as from physical therapy, occupational therapy, speech, neuro-psychological evaluation etc. The case manager may use the supporting records and evaluations in completing the comprehensive assessment and/or determining eligibility for HCBS.

If the case manager determines an individual is not eligible for one of the services allowable in these programs, a formal denial and appeal rights must be issued per ND Admin. Code 75-01-03.

If the individual is accepted into services, the case manager conducts person-centered planning using the required forms and completes the vision tool using the Life Course model. Services are then authorized based on the program guidelines and service maximums for each state or federally funded program. Services are authorized for up to 6 months at a time.

Rural Differential (RD)

An RD rate can be authorized for any client receiving the following services under Medicaid State Plan Personal Care (MSP-PC), Medicaid Waiver (MW), Service Payments to the Elderly Disabled (SPED), and Expanded Service Payments to the Elderly and Disabled (EX-SPED):

- Personal Care
- Homemaker
- Companionship

- Supervision
- Chore Labor (not including shoveling snow)
- Extended Personal Care
- Nurse Education
- Respite Care
- Transitional Living

All appropriate boxes in the application must be completed to be accepted by the HCBS administrator. A MapQuest is required to accompany the SFN 212 (found here https://www.nd.gov/eforms/Doc/sfn00212.pdf). The department checks the QSP's physical address. If the address does not match, no RD will be approved. Agency employees who are not required to first report to their agency due to distance must make their address available to Aging Services/HCBS for verification. The appropriate RD tier and funding source are identified by the case manager or administrator. Each service the client will be receiving along with the rate and start date must be approved by the agency before the client can begin receiving the RD rate.