

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

- A. The State of North Dakota requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. **Program Title:**
Medicaid Waiver for Home and Community Based Services
- C. **Waiver Number:** ND.0273
Original Base Waiver Number: ND.0273.
- D. **Amendment Number:**
- E. **Proposed Effective Date:** (mm/dd/yy)

07/01/18

Approved Effective Date of Waiver being Amended: 04/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

To add Community Transition Services and to further define critical incidents. Community Transition Services will include one-time transition costs and transition coordination. Community Transition Services will assist eligible individuals transitioning from an institutional setting to the community. A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B3(f)
<input checked="" type="checkbox"/> Appendix C – Participant Services	C1/C3; C5
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	G1(b); G1(d)
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	I2(a)
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J2(c)(i); J2(d)

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

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

Specify:

Further define what is considered a critical incident that involves a waiver recipient.

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*):
Medicaid Waiver for Home and Community Based Services

C. Type of Request: amendment

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

- 3 years 5 years

Original Base Waiver Number: ND.0273

Draft ID: ND.001.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/17

Approved Effective Date of Waiver being Amended: 04/01/17

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 in 42 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 Eligibility 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.

Purpose: The Medicaid Waiver for Home and Community Based Services provides service options for a continuum of home and community based services in the least restrictive environment.

Goals and Objectives: The goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. In order to successfully meet the mandate, a consumer-centered, affordable delivery system has been established for delivery of in-home services to the elderly and physically disabled.

To accomplish these goals, an array of services is offered through the waiver. A system has been established to assess the needs of consumers, implement a care plan, monitor the progress of the care plan, and re-evaluate consumer needs on a regular basis.

Partnerships: This system involves a partnership between the local County Social Service Boards, the North Dakota Department of Human Services, informal networks, and consumers/family members. Advocates for consumers have played a significant role in identifying gaps in current Waiver services.

When applicable, other State agencies or other Department of Human Services Divisions have participated in discussions in establishing and maintaining a quality system. They have played a crucial role in the decision making process. Some of the other State agencies and Divisions that have contributed in identifying service needs are: North Dakota Health Department; Protection and Advocacy; ND Department of Human Services Medical Services Division, Developmental Disabilities Division, Behavioral Health Division, Vocational Rehabilitation, and the Legal Services Division.

Several non-governmental entities provided input including: AARP, Independent Living Centers, current and potential consumers, family members, and other service providers.

Service Delivery System: The service delivery system includes individual and agency service providers.

Service providers are enrolled through the Department of Human Services, Medical Services Division. Service providers must display skills competency or provide current licensing/credentialing (when applicable).

Currently, the only case management entities that provide services are (local) county social service boards. Any other case management agencies or individuals who meet the minimum provider requirements are eligible to provide case management services. QSP enrollment books are available on the Department of Human Services website. Interested parties may also request a copy of the enrollment book directly from the Department of Human Services. Technical assistance is provided upon request.

The North Dakota Department of Human Services, Aging Services Division which is part of the State Medicaid Agency will administer the Waiver.

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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewide 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 statewide 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:
- As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
 - 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 inpatients 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 02/07/18 the MMA CMT members were notified of the SMA's intent to amend the HCBS waiver via email. On 02/15/18 DHS sent a notice to all Tribal Chairman, Tribal Health Directors and IHS Representatives in ND notifying them of the SMA's intent to amend the HCBS waiver. Tribal organizations were notified that they could view the waiver on the DHS website or receive a copy upon request. The tribal consultation notification letter was also posted to the DHS website. The required 30 day public comment period was provided. Public comment accepted from 02/15/18 until 03/16/18 at 5:00 p.m. CST. DHS provided opportunities for public comment on the amendment in the following manner: 1) The amendment and public notice was posted to the DHS website www.nd.gov/dhs/info/pubs/medical.html. 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.
- 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:

Schlinger

First Name:

Jennifer

Title:

HCBS Program Administrator

Agency:

ND Department of Human Services

Address:

Aging Services Division

Address 2:

1237 W Divide Ave Suite 6

City:

Bismarck

State:

North Dakota

Zip:

58501

Phone:

(701) 328-8915 Ext: TTY

Fax:

(701) 328-4875

E-mail:

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Dakota**

Zip:

Phone:

 Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

North Dakota Preliminary Transition Plan – Assessment of Settings Process

North Dakota offers seventeen services through its Home & Community Based Services (aged & disabled) 1915(c) waiver. Approximately 1200 providers are enrolled to provide HCBS services. The majority of waiver services are provided individually in the clients' private home and comply with the HCBS settings requirements.

Fourteen agencies are enrolled to provide adult residential services; none are located in or adjacent to a nursing home and none are located on the grounds of a public facility, but some of these settings may not fully comply with the new requirements because they may be considered to have the effect of isolating individuals.

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

From April through July 2014 the Department of Human Services has done a review and analysis of all settings where HCBS (aged and disabled) services are provided to eligible recipients. The analysis included review of North Dakota Century Code, North Dakota Administrative Code, Home and Community Based Services policy, on-site visits to residential service providers,

provider calls, and review of licensing rules and regulations.

Through this process, the state determined the following services with changes, will fully comply with the regulatory requirements because the state will require remedial strategies and timelines for the providers to come into full compliance:

Adult Foster Care: 30 homes serving no more than 4 recipients. The State Medicaid agency has identified the following areas where remediation is needed to comply with HCB characteristics.

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

Remedial strategies include:

- State Medicaid Agency will conduct training for licensing entities and case management.
- State Medicaid Agency will conduct training for licensed AFC providers and require modified house rules to be sent to State licensing agency (Department of Human Services).
- State licensing agency (Department of Human Services) will promulgate AFC rules to modify licensing standards to match HCB setting requirements.
- State Medicaid agency will update policy to reflect changes in administrative rule.
- State Medicaid agency will provide training and sample lease agreements that comply with ND law to AFC providers.
- AFC providers will secure a signed lease or other written rental agreement that includes the eviction process, which must be compliant with ND eviction law (NDCC chap. 47-32)

Assuring Compliance:

State will keep a roster of attendees and dates of training; State licensing agency (Department of Human Services) will review all licensing documents to assure compliance and publish modified rules on ND.gov.

Final completion of all strategies: October of 2016

Through this process, the state also determined the need to submit evidence via the heightened scrutiny process for the following service because it could have the effect of isolating individuals from the broader community.

Adult Residential Services: 14 facilities with a capacity of no more than 36 beds. The State Medicaid agency has identified the following areas where remediation is needed to comply with HCB characteristics:

- Changes are needed in regard to the experience of the recipient to allow for more control including, access to food /snacks at any time, access to phone at any time, allowing for privacy in the living unit including, entrance doors to recipients private areas that lock.
- Changes are needed to comply with the need for a lease or legally enforceable agreement that provides protection to address the eviction process and appeals comparable to ND landlord tenant laws.
- Changes are needed to assure recipients are regularly accessing the community as they choose; understand that they have choices in their daily services and supports, can have visitors at any time and that they are not required to adhere to a specific schedule for waking, bathing, eating, activities etc.

Remedial Strategies Include:

- State Medicaid agency will provide training to the Case Managers and Adult Residential providers on the setting characteristics.
- State Medicaid Agency will work with the Department of Health (licensing and surveying entity) to update regulatory documents to assure compliance with HCB characteristics.
- Adult Residential Service providers will secure a signed lease or other written rental agreement that includes the eviction process, which must be compliant with ND eviction law (NDCC chap. 47-32).
- Requiring providers to submit evidence upon enrollment and reenrollment that their service package offers recipients regular and meaningful opportunities to access the broader community and that direct care staff have been provided with training specific to the care of individuals with dementia or traumatic brain injury. Consumer education materials must include information to Medicaid recipients and families that the consumer has choice in their daily activities, can have visitors at any time, and that they are not required to adhere to a specific schedule.

Assuring Compliance:

State will maintain a roster of attendees and dates of training, publish modified documents on the ND.gov, The Department of Health will incorporate and monitor implementation of the new rules into the onsite survey process, and legally enforceable

agreements will be submitted and reviewed by State staff. Providers will also be required to submit evidence i.e. activity calendars etc. upon enrollment and reenrollment that show meaningful ongoing opportunities for community access for recipients and require providers to submit consumer education materials that include policy that affords recipient choice in their daily activities and schedules and allows access to visitors at any time.

Final completion of all strategies: August of 2017

Public Input Process Initial Statewide Transition Plan:

The Department provided opportunity for public comment on the initial Statewide Transition Plan during the 30 day public comment period beginning October 15, 2014 through November 14, 2014. The initial proposed Statewide Transition Plan was sent to tribal entities and other stakeholders. The plan was available for public comment online and upon request at <http://www.nd.gov/dhs/info/pubs>

A summary of all comments received during the initial public comment period were added to the proposed Statewide Transition Plan and submitted to CMS on November 28, 2014. The state posted the final Statewide Transition Plan with modifications from public comment to the Department's web site on November 28, 2014. Comments and public input on the Statewide transition plan was accepted in the following ways: Email, Phone, Fax, Mail.

Summary of Public Comment on Initial Statewide Transition Plan

Public comments were received from the following individuals or organizations:

The Arc of North Dakota, Protection and Advocacy Project, AARP North Dakota, Pathfinder Parent Center, Designer Genes, LTC Association, Prairie St. Johns, Fargo, Parents of consumers. Comments specific to the HCBS waiver included a desire to have consumer input on assessing adult residential services for compliance. Other commenters questioned if there would be minimum standards for adult foster care house rules and if there was a complaint process for consumers to report problems.

Based on questions and comments from CMS the state posted a Revised Statewide Transition plan and public comments were accepted from February 19, 2016 – through 5:00 PM CT March 20, 2016. On that same day the State held a public stakeholder meeting. The same public input process described above was followed.

Summary of Public Comment on Revised Statewide Transition Plan

Public comments were received from the following individuals or organizations:

CapGrow Partners, Protection and Advocacy Project and individuals who attended the Public Stakeholder Meeting

Comments specific to the HCBS waiver include: Two commenters stated that adult foster care, and adult residential care, could be assumed not to be home and community based by CMS due to the potential for isolating individuals with disabilities. Another commenter asked that any reference to handicapped accessible in the revised Statewide Transition Plan be changed to accessible to account for person first language. One commenter stated that North Dakota should make sure all supported employment is integrated alongside people without disabilities performing work duties and not segregated with just other employees with disabilities.

State responses to the public comments were incorporated into the Revised Statewide transition plan and it was submitted to CMS. CMS asked for technical change to be made to this version of the plan and North Dakota received its initial systemic assessment approval from CMS of its Statewide Transition Plan (STP) effective November 1, 2016. The State is continuing to work on submitting evidence for heightened scrutiny as described in the plan.

The waiver specific transition plan aligns with the most recent STP that received initial approval of the systemic assessment from CMS. The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

It is the intent of the North Dakota Department of Human Services to consult on a regular basis with the Indian Tribes established in North Dakota on matters relating to Medicaid and Children's Health Insurance Program (CHIP) eligibility and

services, which are likely to have a direct impact on the Indian population. This consultation process will ensure that Tribal governments are included in the decision making process when changes in the Medicaid and CHIP programs will affect items such as cost or reductions and additions to the program. The North Dakota Department of Human Services shall engage Tribal consultation with a State Plan Amendment, waiver proposal or amendment, or demonstration project proposal when any of these items will likely have a direct impact on the North Dakota Tribes and/or their Tribal members.

Direct Impact:

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

Consultation:

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

- a. Indian Affairs Commission Meetings
- b. Interim Tribal and State Relations Committee Meetings
- c. Medicaid Medical Advisory Committee Meetings
- d. Independent Tribal Council Meetings

Ongoing Correspondence:

A web link will be located on the North Dakota Department of Human Services website specific to the North Dakota Tribes. Information contained on this link will include: notices described below, proposed and final State Plan amendments, frequently asked questions and other applicable documents.

A specific contact at the North Dakota Department of Human Services Medical Services Division, in addition to the Medicaid Director, will be assigned for all ongoing Tribal needs. This contact information will be disseminated in the continuing correspondence with the North Dakota Tribes.

Content of the written correspondence will include:

Purpose of the proposal/change

Effective date of change

Anticipated impact on Tribal population and programs

Location, Date and Time of Face to Face Consultation OR If Consultation is by Written Correspondence, the Method for providing comments and a timeframe for responses. Responses to written correspondence are due to the Department 30 days after receipt of the written notice.

Meeting Requests:

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

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Aging Services Division
(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight over the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities. The North Dakota Department of Human Services is the single State Medicaid Agency which includes the Aging Services Division and Medical Services. Aging Services Division is responsible for the daily administration and supervision of the waiver, as well as issues, policies, rules and regulations related to the waiver. Oversight of waiver activities is assured through the Department's quarterly waiver coordination meetings which include representatives from Medical Services and other units administering waivers.

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6.

The Department maintains a contract with Dual Diagnosis Management Ascend Management Innovations, LLC. to complete skilled nursing facility level of care determinations that ensures eligibility criteria are met for participation in the waiver.

- 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:

County Social Service Boards perform waiver functions at the local level.
The functions performed by the County Social Service Board include:

- a) Provide information designed to educate people about the availability and services of the HCBS Medicaid waiver programs;
- b) Determine eligibility for, and assist individuals in applying for, Medicaid HCBS waiver benefits;
- c) Make Qualified Service Provider lists available to Medicaid recipients so that they may exercise free choice of providers to the greatest extent possible;
- d) Follow all rules, policies, and direction of the Department in administering the Medicaid HCBS waiver programs; and
- e) Determine level of services to be approved against the limits of the programs.

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:

Aging Services Division, North Dakota Department of Human Services

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:

Counties are reviewed every year, either on-site or via desk audit. Both on-site and desk reviews use the same review guide to evaluate compliance with policy. On site reviews differ from desk reviews because County staff are unaware of the files that will be chosen prior to the review and include client visits, an exit interview, and the provision of technical assistance as it pertains to the review findings.

Dual Diagnosis Management Ascend Management Innovations, LLC. is monitored by daily reporting via web

application, monthly reports from DDM to the State Medicaid agency, input from counties regarding service performance, weekly telephone contact with DDM regarding contract components and input of screening into MMIS assuring timely completion of reviews.

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	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of waiver participant's skilled nursing facility level of care determinations that were completed within 3 business days. N: Number of LOC determinations completed within 3 business days. D: Total number of LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report generated by the State from information contained on the DDM Ascend Management Innovations, LLC. website.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input checked="" type="checkbox"/> Other Specify: Every 6 months	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every six months

Performance Measure:

Number and percent of enrolled case management providers that are carrying out operational and administrative functions according to policy and procedures. N: Number of case management providers that are carrying out administrative functions according to policy D: Total number of case management 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Reviews will be conducted the first and third years of the renewed waiver.	

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

	Sampling Approach(check each that applies):
--	--

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Reviews will be conducted the first and third years of the renewed waiver. Reports / data will be compiled after each review.

Performance Measure:

Number and percent of enrolled case management providers that meet operational and administrative functions as a local non-state entity. N: Number of case management

providers that meet operational and administrative functions. D: Total number of case management providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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- 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. Offsite record reviews will be conducted on a statistically valid number of waiver clients' care plans and assessments to assure Case Management entities manage waiver enrollments against approved limits, adequately perform prior authorizations of waiver services, and assure that waiver requirements are met.

Statistical significance for the desk review of assessments/care plans will be determined by calculating a representative random sample of current waiver recipients based on credible parameters including a 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution. The state will use a research number randomizer to choose which waiver cases to review.

All Case Management providers will be required to submit a report annually to the State Medicaid Agency describing how they carry out the following delegated administrative functions: disseminate information concerning the waiver to potential enrollees, assist individuals in waiver enrollment, and recruit providers. The information in the reports will then be evaluated by the State Medicaid agency to assure they are adequately administering these delegated functions.

b. Methods for Remediation/Fixing Individual Problems

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Off site reviews will be conducted the first and third years of the renewed waiver. Reports/data will be compiled after each review.

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
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18	64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Additional Criteria for Disabled (Physical) -If under 65 an individual must be determined physically disabled by the Social Security Administration or by the State Review Team.

Additional Criteria for Disabled (other) - The disabled (other) group includes individuals with brain injury and dementia.

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:

Once an individual turns 65 they are considered aged and are still eligible for the waiver if they meet all of the other eligibility criteria.

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 Human Services. Rates are published once per year. Current rates are available by contacting the Department of Human Services Rate Setting Administrator.

Care plans for all waiver recipients must be submitted to the State Medicaid agency when services are initiated and every time services change thereafter. Reviewing the care plan and authorizing services includes assuring that the total cost of waived 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.

- 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:

A comprehensive assessment will identify the formal and informal service needs of the individual and provider availability. If the plan of care could not assure the health, welfare, and safety of the individual, services would be denied. The individual would receive appropriate notification of appeal rights.

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Case management services will assist the individual to identify other community resources or options. If the comprehensive assessment identifies that the formal and informal service needs of the individual and provider availability are not adequate to assure the health, welfare, and safety of the individual then services would be terminated. The individual would receive appropriate notification of appeal rights.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	496
Year 2	516
Year 3	537
Year 4	558
Year 5	580

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

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:

Case managers assess the need for services through a comprehensive assessment. Prior approval is required for the following services: environmental modification, specialized equipment, adult residential care, transitional care, extended personal care services, supervision, community transition services, chore services in excess of \$200 per month, and for homemaker services when the participant is living with a capable person or provider. Cost proposals for environmental modification and specialized equipment are reviewed to assure that preliminary costs do not exceed the individual cost limit.

Once eligibility is determined, the applicant must choose an enrolled service provider(s). Entrance into the Waiver occurs, once all eligibility criteria have been met, and the service provider is authorized. With the exception of the services described above, case managers authorize Waiver services without prior approval from the Department. The Department currently does not have a waiting list for the Home and Community Based Services Waiver.

In the event projections would reflect a potential waiting list, either due to restricted capacity levels or appropriation shortfalls, the Department will require the case managers to seek prior approval for a Waiver slot. The Department would approve services on a first come/first serve basis once a pre-approval package, reflecting that eligibility criteria has been met, is forwarded to the State.

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (2 of 7)**

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

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

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (3 of 7)**

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

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

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

i. Allowance for the needs of the waiver participant (select one): **The following standard included under the State plan**

(select one):

 The following standard under 42 CFR §435.121

Specify:

 Optional State supplement standard **Medically needy income standard** **The special income level for institutionalized persons**

(select one):

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

Specify percentage:

 A dollar amount which is less than 300%.

Specify dollar amount:

 A percentage of the Federal poverty level

Specify percentage:

 Other standard included under the State Plan

Specify:

 The following dollar amount

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

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

Specify:

- Other

Specify:

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

- Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

- The following standard under 42 CFR §435.121

Specify:

- Optional State supplement standard

- Medically needy income standard

- The following dollar amount:

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

- The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)

- AFDC need standard

- Medically needy income standard

- The following dollar amount:

Specify dollar amount: 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:

- 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:

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

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

Specify the entity:

Dual Diagnosis Management Ascend Management Innovations, LLC.

- 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:

Registered, Licensed Practical, or Licensed Vocational 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 to evaluate and reevaluate whether an individual needs services through the waiver is entitled the Level of Care (LOC) Determination form. The completed document must be approved by the Dual Diagnosis Management Ascend Management Innovations, LLC. to verify that the individual meets nursing facility level of care, as defined in North Dakota Administrative Code (N.D.A.C) 75-02-02-09.

The LOC form assesses the client's health care needs, cognitive abilities, functional status, and restorative potential.

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

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

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

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

The case manager meets with the client and completes a functional assessment. They obtain collateral information as appropriate from family, medical professionals and provide this information to Dual Diagnosis Management Ascend Management Innovations, LLC (DDM), which allows DDM to complete the level of care determination. Once a determination is made, a copy of the determination response is forwarded to the case manager and is available to the Department via DDM's website. DDM is a contracted entity; the contract is monitored by a Medical Services Division Program Administrator.

The same process is required for initial or re-evaluations of level of care.

- 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*):

Case Managers are responsible to retain a schedule of when re-evaluations are due. Case Managers have access to a report that is available on DDM's website to help them track the reevaluation dates of their cases. The State Medicaid Office runs a report each week of the level of care screenings that were approved by DDM and enters the level of care screening dates into the MMIS system. The State Medicaid office also monitors level of care reevaluations quarterly as part of our quality improvement process to assure that all level of care evaluations are current. If a problem is found, the State Medicaid Agency contacts the Case Manager directly to correct the issue.

- 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:

Case management entities retain copies of the instrument and approvals/denials of screenings. Dual Diagnosis Management Ascend Management Innovations, LLC, retains records that are available to the Department via their website. The website is available to the State Medicaid agency and allows us to electronically generate reports and documentation of NF LOC screening and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care
Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of all new enrollees who have a level of care (LOC) indicating need for nursing facility (NF) LOC, prior to the receipt of services. N: Number of new enrollees who have a LOC completed prior to entry into the waiver. D: Total number of new enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

A report generated from DDM Ascend Management Innovations, LLC. that lists completed screenings will be verified against a State generated MMIS report that identifies all enrolled waiver participants.

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):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: A report generated from DDM Ascend Management Innovations, LLC. that lists completed screenings will be verified against a State generated MMIS report that identifies all enrolled waiver participants.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 annual level of care (LOC) determinations made by a qualified reviewer. N: Number of annual LOC made by a qualified review. D: All annual level of care determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDM Ascend report that lists the names of the reviewer, who completed each screening, will be verified against the reviewer's credentials that are required to be submitted to the State.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: DDM Ascend report that lists the names of	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

the reviewer, who completed each screening, will be verified against the reviewer's credentials that are required to be submitted to the State.		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number and percent of level of care (LOC) determinations made on the correct form and the LOC criteria applied appropriately. N: Number of LOC determinations made on the correct form and applied appropriate criteria. D: All LOC determinations.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of initial level of care (LOC) determinations made by a qualified reviewer. N: Number of initial LOC determinations made by a qualified reviewer D: All initial LOC determinations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

DDM Ascend report that lists the names of the reviewer, who completed each screening, will be verified against the reviewer's credentials that are required to be submitted to the State.

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: DDM Ascend report that lists the names of the reviewer, who completed each screening, will be verified against the reviewer's credentials that are required to be submitted to the State.	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The State requires all screenings to be completed on a standardized tool. The State contracts with Dual Diagnosis Management Ascend Management Innovations, LLC. to complete all LOC screenings. The contract requires that all LOC screenings be performed by a registered nurse or by licensed practical nurses, with at least three years of experience in behavioral health and three years of geriatric experience, receiving direct supervision from a registered nurse with a minimum of three years of psychiatric and three years of geriatric experience.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

It is the responsibility of 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, group training, recoupment of funds, amending the contract, or termination of contract for non-compliance if necessary. 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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).

The State Medicaid agency requires the case management entity to obtain signatures of applicants/consumers or legal representatives on the following forms: Explanation of Client Choice SFN 1597, Application for Service SFN 1047, and the Person Centered Plan of Care SFN 404.

These documents allow the applicant/consumer or legal representative to indicate that they have agreed to choose waiver services versus institutional care; that they have chosen their service provider(s), have accepted a plan of care; and that they have been informed of the right to appeal if dissatisfied or not in agreement with services.

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

The case management entity maintains all forms. Additionally, the Explanation of Client Choice (SFN 1597) and Person Centered Plan of Care (SFN 404) are both forwarded to the State Medicaid 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 is unable to independently communicate with a case manager or State reviewer, a family member or community interpreter is present.

The Department has a limited English proficiency implementation plan that provides guidelines and resources. The plan is posted on the Department's website.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Care		
Statutory Service	Adult Residential Care		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Respite Care		
Statutory Service	Supported Employment		
Other Service	Adult Foster Care		
Other Service	Chore		
Other Service	Community Transition Services		
Other Service	Emergency Response		
Other Service	Environmental Modification		

Service Type	Service		
Other Service	Extended Personal Care		
Other Service	Family Personal Care		
Other Service	Home Delivered Meals		
Other Service	Non-Medical Transportation		
Other Service	Specialized Equipment & Supplies		
Other Service	Supervision		
Other Service	Transitional Living		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Adult Day Care is a community-based service offered within an approved group setting designed to meet the needs of functionally impaired adults. It is a structured, comprehensive service that provides a variety of social and related support services in a protective setting during a part of a day. Meals provided as a part of these services shall not constitute a full, nutritional regimen (3 meals/day). Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring for an impaired member at home.

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

Minimum of 3 hours per day through a maximum of 10 hours per day, on a regularly scheduled basis, for one or more days per week.

Non medical transportation may be included as a part of this service and is included in the rate.

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	Individuals & Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Individuals & Agency

Provider Qualifications

License (specify):

Agency only - N.D.C.C. 23-16; N.D.A.C. 33-07-01; 33-07-03.1; N.D.A.C. 33-03-24.1-10

Certificate (specify):

Other Standard (specify):

Individual - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Adult Residential Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services	02011 group living, residential habilitation
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Category 2:

Sub-Category 2:

	W
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Category 3:

Sub-Category 3:

	W
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Category 4:

Sub-Category 4:

	W
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Service Definition (Scope):

A residential program specializing in care of individuals with chronic moderate to severe memory loss or an individual who has a significant emotional, behavioral, or cognitive impairments and needs the services of: independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building. Or the individual may require protective oversight and supervision in a structured environment that is professionally staffed to monitor, evaluate and accommodate an individual's changing needs. It is also a service in which assistance with ADL's/IADL's, therapeutic, social, and recreational programming is provided. Care must be furnished in a way that fosters the maintenance or improvement, as appropriate, in independence of the recipient.

Participants are free to choose between all types of residential services. Individuals indicate on the care plan that they are in agreement with the services and have made an independent choice of provider.

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

This service includes 24-hour on-site response staff. Medication administration is allowed at the least costly means permitted by State Law. Non-medical transportation may be provided as a component of this service and is included in the rate. Payment for residential services are not made for room and board, items of comfort or convenience, or the costs of building maintenance, upkeep and improvement. The agency must provide services to at least five adults; provide personal cares, therapeutic, social, and recreational programming.

Pre-approval from the Department of Human Services is required before this service can be authorized.

Residential settings that serve less than five individuals are defined in N.D.C.C. 50-11 as Adult Foster Care (AFC) homes and do not apply to adult residential settings. The needs of individuals residing in AFC homes are governed under the licensing requirements in N.D.C.C. 50-11 and N.D.A.C. 75-03-21.

To avoid duplication homemaker, chore, emergency response system, adult day care, adult foster care, respite, transitional care, extended personal care, environmental modification, home delivered meals, family personal care and non-medical transportation are not allowable service combinations for individuals receiving adult residential services. Non-medical transportation is not allowed because it included in the rate for adult residential services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Residential Care

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

N.D.A.C. 33-03-24.1

Certificate (specify):

Other Standard (specify):

Agency - Licensed as a Basic Care facility with experience providing services to individuals with a diagnosis of either dementia or brain injury. Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07 and have programming to meet recipient's needs.

Adult Residential providers are required to submit an assurance that they will report medication errors or omissions per policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

01 Case Management

010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



Service Definition (Scope):

Case management assists functionally impaired individuals to achieve and maintain independent living in the living arrangement of their choice. The service is provided until the recipient can no longer be served on the waiver. The case manager assists individuals to gain access to waiver and other formal/informal services. Case managers assist the client to explore and understand options, make informed choices, solve problems, and provide a link between community resources, qualified service providers, and the client.

Case management requires the completion of a comprehensive assessment of needs, care planning, implementing care plan, monitoring, reassessing, and closure/termination of services.

Recipients may choose an agency or independent case management provider.

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

An initial evaluation will be provided to an applicant to determine Waiver eligibility. Thereafter, at a minimum, quarterly face to face contacts are required.

All case management requires participation in care plan meetings with an interdisciplinary team; prior approval from the Department is not required. All cases require frequent face to face visits to assist with care plan development and monitoring.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency & Individual

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:

Agency & Individual

Provider Qualifications

License (specify):

ND SW License N.D.C.C. 43-41-01 to 43-41-14; N.D.A.C. 75.5-01 and 75.5-02

A person may not engage in the private practice of social work in North Dakota unless that person has been licensed by the board as a licensed independent clinical social worker (LICSW). Private practice of social work means the independent practice of social work by a qualified individual who is self-employed on a full-time or part-time basis and is responsible for that independent practice. LICSW

means an individual who has a doctorate or master's degree in social work from a college or university and who has fulfilled the requirements for licensure or has been registered by the board for third-party reimbursement before August 1, 1997.

Individuals enrolled as LICSWs in North Dakota may enroll and provide independent case management services to waiver recipients.

Certificate (specify):

Other Standard (specify):

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

The purpose of homemaker service is to complete intermittent or occasional environmental tasks that an elderly or disabled individual is not able to complete in order to maintain that individual's home such as housework, meal preparation, laundry, shopping, communication, and managing money.

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

Homemaker service is offered to individuals living alone or living with an individual that is incapacitated and unable to perform the homemaking tasks. If the individual lives with a capable person or provider, prior approval from the State office is required. Homemaker services cannot be provided in a provider owned setting.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. This amount allows for approximately 12 hours of service per month at the highest provider rate allowed. If a participant has a need for cleaning of an unusual nature chore services would be authorized. This cap may be increased as determined by legislative action. The case manager makes participants aware of the service cap.

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
 Service Name: Homemaker

Provider Category:

Individual ▾

Provider Type:

Individual & Agencies

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Individuals - demonstrating competency in homemaker standards -Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agencies - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

09 Caregiver Support 09012 respite, in-home

Category 2:

Sub-Category 2:

09 Caregiver Support 09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Respite Care is for the purpose of providing temporary relief to the individual's primary care provider from the stresses and demands associated with constant care or in emergencies. Federal Financial Participation (FFP) may not be claimed for room and board when respite is provided in the participant's home or place of residence.

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

The primary caregiver's need for relief is intermittent or occasional; the client requires a qualified caregiver during the primary caregiver's absence; and/or the relief is not for the primary caregiver's employment or to attend school. Respite care can be provided in the clients residence, adult foster care home, hospital, nursing facility, swing bed facility, or in the private home of approved respite home care provider.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. The cap allows for approximately 9 hours of in-home respite care per week at the maximum provider rate allowed or 4 days of institutional respite care per month. If multiple clients live in the same home and have the same primary caregiver the respite cap must be divided by the number of client's in the home however, additional dollars may be added to the allocation for each additional client served. Additional respite dollars may be allocated because primary caregivers who are providing care to more than one client at a time are more likely to need additional respite care because of increased caregiver burden. The per day cost of institutional or in-home respite care cannot exceed the swing bed rate. These caps may be increased as determined by legislative action.

The Department of Human Services may grant approval to exceed the service cap if the client has special or unique circumstances; the need for additional services does not exceed 3 months; and the total need for service does not exceed the individualized budget amount. Under emergency circumstances, the Department may grant a one-time extension not to exceed an additional three months. The case manager makes participants aware of the service cap.

To avoid duplication, respite care cannot be provided to individuals receiving adult residential services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
 Service Name: Respite Care

Provider Category:

Individual ▾

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):

Agency only - N.D.C.C. 23-16, N.D.A.C. 33-07-01, 33-07-03.2 N.D.A.C. 33-03-24.1

Certificate (specify):

Other Standard (specify):

Individual - Demonstrating competency in respite care standards - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Basic Care, Swing Bed, and Nursing Facilities that provide respite care are required to submit an assurance that they will report medication errors or omissions per policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▾

Service:

Supported Employment ▾

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

03 Supported Employment

03021 ongoing supported employment, individual ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Supported employment includes activities needed to sustain paid work including supervision and training for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need the provision of intensive, ongoing support to perform in a work setting with necessary adaptations, supervision, and training appropriate to the person's disability.

Supported employment recipients must work in a competitive work setting i.e. hotels, restaurants, retail establishments, offices, home based self-employment etc. All individuals currently utilizing this service are working in competitive work settings. This service includes individualized training and is not conducted in a group setting.

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

Supported employment cannot be provided in any setting that would isolate recipients from the community i.e. sheltered workshops etc. Services may not be provided in group settings.

Activities would not include supervision or training activities provided in a typical business setting nor prevocational skills development. Service tasks will only be authorized for the adaptations, supervision, and training required by the client as a result of their disability. Transportation will be provided as an aspect of this program and the cost is included in the rate paid to providers of this service.

Documentation is maintained in the file of each participant that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) and that they have completed the supported employment program available through Vocational Rehabilitation. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

CARF or N.D.A.C. 75-04-01

Certificate (specify):

Other Standard (specify):

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Foster Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

2021 shared living, residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

[Empty text box with a small icon on the right]

Service Definition (Scope):

Assistance with ADL's, IADLs and supportive services provided in a licensed private home by a care provider that lives in the home. Adult foster care is provided to adults who receive these services while residing in a licensed home. The total number of individuals who live in the home who are unrelated to the care provider cannot exceed four.

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

Service must be provided in a licensed Adult Foster Care (AFC) home. Services are provided to the extent permitted under state law. To avoid duplication homemaker, chore, emergency response system, residential care, transitional care, home delivered meals, family personal care, environmental modification, supervision, and non-medical transportation are not allowable service combinations for individuals receiving AFC. Non- medical transportation is a component of AFC and is included in the rate.

The cost of this service is limited to a maximum monthly cap set by the Department. If the client's needs cannot be met within the allowed rate case management would explore other waiver service options with the participant. The case manager makes participants aware of the service cap.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:

Individual [dropdown arrow]

Provider Type:

Individual

Provider Qualifications

License (specify):

Adult Foster Care (AFC) licenses - N.D.C.C. 50-11; N.D.A.C. 75-03-21

Certificate (specify):

[Empty text box with a small icon on the right]

Other Standard (specify):

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Aging Services Division (background check verification & licensing) & Medical Services Division (provider enrollment)

Frequency of Verification:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Chore

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

98060 chore ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

Chore Service is provided to complete tasks, which an elderly or disabled individual is not able to complete in order to remain independent in his/her own home. Tasks include activities such as cleaning of an unusual nature, moving heavy furniture, floor care of unusual nature, cleaning of appliances, snow removal, professional extermination or sanitation. The tasks authorized must be directly related to the health and safety of the client.

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

Chore services cannot duplicate the services provided under homemaker. Chore tasks may include but are not limited to pest control, snow removal, heavy spring cleaning etc. They are provided on a one-time or intermittent bases and must be provided in the client's home. Chore service is not authorized if the tasks are the responsibility of the landlord. These services will be provided only in cases where the client or any other adult in the household is not capable of performing the activity.

Pre approval from the Department of Human Services team is required if the cost of the service is expected to exceed \$200 per month. The State also monitors this service through case management audits that are conducted annually.

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	Agency & Individual

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Chore

Provider Category:

Individual ▼

Provider Type:

Agency & Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual - Demonstrating competency in chore standards - Enrolled Qualified Service Provider (QSP)
 N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
<input type="text" value="16 Community Transition Services"/>	<input type="text" value="6010 community transition services"/>
Category 2:	Sub-Category 2:
<input type="text"/>	<input type="text" value="W"/>
Category 3:	Sub-Category 3:
<input type="text"/>	<input type="text" value="W"/>
Category 4:	Sub-Category 4:
<input type="text"/>	<input type="text" value="W"/>

Service Definition (Scope):

The purpose of Community Transition Services is to assist eligible individuals transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the client is directly responsible for his or her own living expenses and needs non-recurring set-up expenses. Community transition services include one-time transition costs and transition coordination. Transition coordination assists an individual to procure one-time moving costs and/or arrange for all non-Medicaid services necessary to help them transition from the institution to home.

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

Community Transition Services do not include expenses that constitute room and board; monthly rental or mortgage expense; escrow; specials; insurance; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person and 90 days from the date the client became eligible for the waiver. Transition coordination is limited to 300 hours per year per recipient. One-time transition costs are limited to \$3000 per eligible individual for WY 2 plus 3% inflation WY 3-5.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):

Agency staff: Completion of an associate or bachelor’s degree in sociology, social services, social work, nursing, or a field related to programmatic needs from an accredited university. Staff with an associate degree must also have at least one year of progressively responsible experience in programs related to the task.

Individual providers: Completion of a bachelor’s degree in sociology, social services, social work, nursing, or a field related to programmatic needs from an accredited university.

Certificate (specify):

[Empty text box with a scroll bar]

Other Standard (specify):

Individual - Enrolled Medicaid Provider and Enrolled Qualified Service Provider (QSP) NDAC 75-03-23-07

Agency - Enrolled Medicaid Provider and Enrolled QSP NDAC 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service [dropdown arrow]

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:

Emergency Response

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications [dropdown arrow] 4010 personal emergency response system (PERS) [dropdown arrow]

Category 2:

Sub-Category 2:

[Empty text box with a scroll bar]

Category 3:

Sub-Category 3:

[Empty text box with a scroll bar]

Category 4:

Sub-Category 4:

[Empty text box with a scroll bar]

Service Definition (Scope):

The purpose of Emergency Response Systems is to allow individuals to access emergency call systems during the absence of human assistance.

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

Limited to persons cognitively and physically capable of activating the emergency call. This service is not available to individuals who live with someone unless the individual is incapacitated or their periodic absence presents a safety risk.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Emergency Response

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modification

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

4020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Environmental modification is physical adaptations to the home required by the individuals' plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence, and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and are necessary for the welfare of the recipient.

Funds for this service may be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a recipient living in their own home or in the home of their family member. This home must be owned by the recipient or the recipient's family member.

A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the recipient if the estimated cost of the modification is more than \$250. The cost of the assessment to provide a written recommendation is an allowable expense if the cost of the assessment is not covered under the State Plan. The cost of the evaluation must be included in the cost estimate submitted to the Department and the total cost of the modification and the assessment cannot exceed the current funding cap.

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

Modifications may be made to a home owned by a recipient or the home of the recipient's family member if the recipient resides in that home. Modifications will enable the recipient to provide self-care or receive care and allows the recipient to safely stay in the home for a period of time that is long enough to offset the cost of the modification. Modifications are not for routine home maintenance, (such as carpeting and/or floor repair, plumbing repair, roof repair, central air conditioning, appliance repair, electrical repair, etc.) but are to promote independence. Adaptations, which add to the total square footage of the home, are not allowed. All services shall be provided in accordance with applicable state and local building codes.

For environmental modification the dollar limit cannot exceed the current highest monthly rate for the highest cost skilled nursing facility. Exceptions to this service cap will not be made. The cost of the evaluation must be included in the cost estimate submitted to the Department and the total cost of the modification and the assessment cannot exceed the current funding cap. If the recipient's needs cannot be met within the allowed rate case management would explore other service options with the participant. The case manager makes participants aware of the service cap.

All medically necessary services for children including environmental modification are covered under Early Periodic Screening Diagnosis and Testing (EPSDT).

Pre-approval from the Department of Human Services is required before this service can be authorized.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Environmental Modification

Provider Category:

Individual ▾

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):

Contractors, Electricians or Plumbers - N.D.C.C. 43-07, 43-09, N.D.C.C. 43-18

Certificate (specify):

Other Standard (specify):

Tradesmen Qualification Requirements

Individual - Bonded, Licensed, Enrolled with Secretary of State, and in good standing with Workforce

Safety - General Contractor, Plumber, Electrician - Enrolled Qualified Service Provider (QSP)

N.D.A.C. 75-03-23-07

Agency - Bonded, Licensed, Enrolled with Secretary of State, and in good standing with Workforce

Safety - General Contractor, Plumber, Electrician - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Extended Personal Care

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

11 Other Health and Therapeutic Services

010 health monitoring

Category 2:**Sub-Category 2:**

11 Other Health and Therapeutic Services

020 health assessment

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

05 Nursing

05020 skilled nursing

Service Definition (Scope):

Extended personal care includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service may include skilled or nursing care to the extent permitted by State law.

A nurse, licensed to practice in the state, will be reimbursed to provide training to an individual approved by the Department who will be reimbursed to perform the required care. Or, if a necessary medical task is too complex to be taught to an unlicensed provider the nurse may be paid to provide the service directly to the client. The nurse educator will provide at a minimum, a review of the client's needs every six months to determine if additional training and or tasks are required. Activities of daily living and instrumental activities of daily living are not a part of this service.

The licensed nurse is required to participate in the development of a plan of care for individuals who require assistance with maintenance of routine nursing tasks. Other requirements include following established protocol for reporting incidents to the Department of Human Services.

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

Activities of daily living and instrumental activities of daily living are not a part of this service. The need for extended personal care is limited to individuals who have cognitive or physical impairments that prevent them from performing these activities. Individuals who have cognitive impairments and are not able to participate in the training process are required to have a legally responsible person present during the training.

Pre-approval from the Department of Human Services is required before this service can be authorized. To avoid duplication, individuals who are receiving extended personal care are not eligible for family personal care and adult residential services.

Extended Personal Care is provided only when the services are not available through the Medicaid State Plan, Early Periodic Screening Diagnosis and Testing (EPSDT), under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or available through a third party resource.

Home Health is different from extended personal care because it is delivered through a home health agency and provided by a nurse that is providing skilled care for an acute condition. Extended personal Care Services are services delivered by a Qualified Service Provider that has been specifically trained by a nurse educator to perform the delegated task. One example of EPCS would be administering medications to a medically stable client or dressing changes for a wound that is healing. The training is specific to the client and information must be sent to the Department clarifying that the training was done to the QSP and the QSP successfully carried out the task. The case manager assures the services being provided to the client are not duplicative of home health services while visiting the client and doing a thorough assessment.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Extended Personal Care

Provider Category:

Individual ▼

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):
 Nurse Educator:

Individual - N.D.C.C. 43-12.1; N.D.A.C. (54-02, 54-05)

Agency - N.D.C.C. 43-12.1; N.D.A.C. (54-02, 54-05)

An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board of nursing; submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought; pass an examination approved by the board of nursing.

An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board; submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought; submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure; submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

Certificate (specify):

Other Standard (specify):

Individual- Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

Extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions per policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Personal Care

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services 02033 in-home round-the-clock services, other

Category 2:

Sub-Category 2:

17 Other Services 07990 other

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Family personal care assists individuals to remain with their family members and in their own communities by allowing individuals who want to choose their legal spouse as their personal care service provider an option of receiving personal care services under the waiver. Currently personal care services are only available under the Medicaid State Plan and individuals cannot choose their legal spouse as their primary care provider.

Family personal care provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.

Personal care or similar services includes, assistance with the ADL's/ IADL's of bathing/ hygiene, dressing, incontinence care, toileting, transferring/positioning, mobility and feeding/eating. It also includes assistance with the tasks of eye care, medication assistance, cognitive supervision, exercise, hoier lift/mechanized bath chairs, indwelling catheter, medical gases, prosthetic orthotics, suppository/ bowel program, ted socks, vital signs, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage and specialty bed.

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

Payment will only be made to legal spouses who reside in the same home. Individuals who choose a provider who is not their legal spouse will be served under Medicaid State plan personal care.

Payment will not be made for assistance with the tasks of communication, community integration, housework, laundry, meal preparation, money management, shopping, social appropriateness, and transportation.

This service cannot duplicate personal care that must be provided as part of an Individual Education Plan (IEP) as required by the Individual with Disabilities Education Act while a recipient is attending school. Case managers are required to assure that other third party funding sources do not duplicate waived services.

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. This cap may be increased as determined by legislative action.

To avoid duplication, family personal care recipients are not eligible for adult residential care, adult foster care, extended personal care, and transitional living.

Family Personal Care is not available to individuals who are eligible to receive such services through the Medicaid State Plan or Early Periodic Screening Diagnosis and Testing (EPSDT).

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	Individuals

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Family Personal Care

Provider Category:

Individual ▼

Provider Type:

Individuals

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals- demonstrating competency in family personal care standards -Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services
C-1/C-3: Service Specification

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

Service Type:

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:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

Sub-Category 1:

06 Home Delivered Meals

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

The provision of nutritious and well-balanced meals to individuals who live alone and are unable to prepare an adequate meal for themselves or who live with an individual who is unable or not available to prepare and adequate meal.

At a minimum, each meal must meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Americans.

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

This service is limited to no more than 7 hot or frozen meals per week. Individuals requesting home delivered meals under the HCBS waiver are not required to use Older American Act meals first. Per federal guidance received from the Administration on Community Living services provided under the Older Americans Act are an exception to the "Medicaid payer of last resort" rule.

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	Individual or Agency

Provider Category	Provider Type Title
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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Individual or Agency

Provider Qualifications

License (specify):

Licensed, as a ND food establishment per N.D.C.C. 23-09 - Does not pertain to hospitals, nursing homes, basic care facilities, and OAA nutrition providers, or facilities that prepare and ship meals nationally which must be licensed and regulated by the U.S. Department of Agriculture.

Hospitals - N.D.C.C. 23-16 & N.D.A.C. 33-07-01.1 (Dietary Service Standards)& N.D.A.C. 33-07-02.1 (General Construction/Equipment Standards)

Nursing Facilities - N.D.C.C. 23-16 & N.D.A.C. 33-07-03.2 (Dietary Service Standards) & N.D.A.C. 33-07-04.2 (General Construction Equipment Standards)

Basic Care - N.D.C.C. 23-09.3 & N.D.A.C. 33-03-24.1 (Dietary Service Standards)

Certificate (specify):

Other Standard (specify):

Individual - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agency - Enrolled QSP N.D.A.C. 75-03-23-07

OAA Nutrition Providers are required to comply with all requirements contained in the State and Community Programs funded under the Older Americans Act Service Chapter 650-25-45 Nutrition Program Standard.

Hospitals certified to participate in the Medicare and Medicaid Program are required to meet federal dietary service standards under 42 CFR 482.28. Nursing facilities certified to participate in the Medicare and Medicaid Program are required to meet federal dietary service standards per 42 CFR 483.35.

In addition, all providers are required to meet all applicable federal, state, and local laws and regulations regarding the safe and sanitary handling of food, equipment, supplies, and materials used in storage, preparation, and delivery of meals to eligible recipients pursuant to the North Dakota Requirements for Food and Beverage Establishments (N.D.A.C. 33-33-04).

Verification of Provider Qualifications

Entity Responsible for Verification:

The licensing and inspection of ND food establishments is the responsibility of the State Health Department or local health jurisdiction. The licensing and inspection of facilities that prepare and ship meals nationally is the responsibility of the U.S. Department of Agriculture.

The licensing and surveying of hospitals, nursing homes and basic care facilities is the responsibility of the ND Department of Health.

Aging Services Division is responsible to conduct meal site assessments of OAA nutrition providers to assure compliance with OAA standards.

The Department of Human Services Medical Services Division – HCBS is responsible for enrolling home delivered meal providers as Qualified Service Providers (QSP).

Frequency of Verification:

QSPs must provide verification at initial enrolment or re-enrollment which is required every two years, and /or upon notification of a provider status change. ND licensed food establishments that request to enroll as a QSP to provide home delivered meals are also required to submit a 4 week cycle menu which will be reviewed by a licensed dietician or nutritionist pursuant to N.D.A.C. 43-44. The menus are reviewed to assure they meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Americans.

OAA nutrition providers, hospitals, nursing homes and basic care facilities are not required to submit sample menus because their menus are reviewed when they contract with Aging Services Division or are licensed by the Department of Health. Facilities regulated by the Department of Agriculture must submit proof that their meals meet the USDA's Dietary Guidelines for Americans.

Non-accredited hospitals are surveyed at initial licensing and certification and recertified by on-site survey approximately every 4-5 years. In addition, hospitals are licensed or re-licensed annually without an on-site survey.

Nursing Facilities initial certification and recertification plus re-licensure is conducted by an annual survey.

Basic Care Facilities the frequency of survey is not mandated. These facilities are re licensed annually but the on-site survey is completed on the average of 3-4 years as funding allows.

ND Licensed Food Establishments undergo a preoperational inspection. The Department of Health conducts more frequent inspections based upon its assessment of a food establishment's history of compliance with the N.D.A.C. 33-33-04 Food Code and the establishment's potential as a vector of food borne illness.

USDA facilities undergo an initial inspection and regulated facilities are visited at a frequency that is appropriate to ensure that selected establishments are operating in a manner that is consistent with the Federal Meat Inspection Act, Poultry Products Inspection Act, and or Egg Products Inspection Act.

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:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

15 Non-Medical Transportation	5010 non-medical transportation <input checked="" type="checkbox"/>
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Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

To enable individuals to access essential community resources or services in order to maintain themselves in their home and community.

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

With the exception of transitional care services, service tasks would not include transporting clients to/from work or school nor to facilitate socialization, to participate in recreational activities, or to medical appointments. This service is not available when transportation is provided as a component part of another service including transportation provided under an Individual Education Plan (IEP) as required by the Individual with Disabilities Education Act. Case Managers are required to assure that other third party funding sources do not duplicate waiver services. State office staff review individual care plans to assure that the combination of services does not allow duplication of non-medical transportation.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual ▾

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):

Individual - N.D.C.C. 39-06

Agency - N.D.C.C. 39-06

Certificate (specify):

Other Standard (specify):

Individuals- must have valid drivers license, road worthy vehicle, clear driving records, and proof of insurance. Be enrolled as a Qualified Service Provider(QSP) per N.D.A.C. 75-03-23-07. If a provider will be using another individual's vehicle to provide this service the owner of that vehicle must provide

proof of insurance and a written statement that they have given the provider permission to use the vehicle for this purpose.

Agency -Enrolled QSP per N.D.A.C. 75-03-23-07. If an agency employee will be using another individual's vehicle to provide this service the owner of that vehicle must provide the proof of insurance and a written statement that they have given the provider permission to use the vehicle for this purpose.

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Specialized Equipment & Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications 4031 equipment and technology

Category 2:

Sub-Category 2:

14 Equipment, Technology, and Modifications 4032 supplies

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Specialized equipment, supplies, safety devices, or assistive technology that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These goods must not be attainable through other informal or formal resources. Items reimbursed with waiver funds are only for medical equipment and supplies not covered under the State Plan; and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture and design. Coverage may include the cost of set up, maintenance, and upkeep of equipment, and may also include the cost of training the participant or caregivers in the operation and/or maintenance of the equipment.

Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:

- 1) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- 2) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- 3) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- 4) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- 5) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

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

- The goods can only include the purchasing of items that relate directly to the clients care needs.
- Goods requiring structural changes to the home are not allowed through this service.
- Pre-approval from the Department of Human Services is required before this service can be authorized.
- Participants 18-21 will receive this service if deemed medically necessary as EPSDT under the state plan.
- A written recommendation must be obtained by an appropriate professional (OT, PT,SLP etc.) to ensure that the equipment will meet the needs of the participant prior to consideration for approval.
- Generic technical devices (tablets, computers, etc.) are not allowed.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Equipment & Supplies

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supervision

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

02033 in-home round-the-clock services, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Up to 24 hours of supervision may be provided to individuals who because of their assessed need require monitoring to assure their continued health and safety. Supervision may be provided to assist waiver recipients who live alone or with an individual who is not identified as a relative under subsection 4 of N.D.C.C. 50-06.2-02. The service may also be available to recipients who live with a relative but the relative is unable to provide supervision because of a physical or cognitive impairment.

Supervision means having the knowledge of, and account for, the activity and whereabouts of the recipient at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. During the time that the provider is supervising the recipient they may play games, visit, read, and participate in activities with the client. If the client is physically able, they may also participate in activities in or around the recipient's home such as gardening, or going for short walks etc.

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

Supervision can only be authorized during the time that no other services are being provided to the recipient. Providers, who provide supervision at night while the client is sleeping, must stay awake while providing supervision.

Supervision can be authorized with the following services, but payment for supervision cannot be claimed, during the time these services are being provided: Homemaker, Extended Personal Care, Chore, Non-Medical Transportation, Medicaid State Plan Personal Care, Transitional Care, Supported Employment, Adult Day Care,

and Community Transition Services. Supervision cannot duplicate the services provided under transitional living.

To avoid duplication of services Supervision cannot be combined with: Respite Care, Adult Foster Care, Residential Services, and Family Personal Care as supervision is already an allowable task under these services. Supervision cannot be combined with an Emergency Response System as this service is not meant to replace the need for human intervention.

Supervision does not include taking/ transporting recipients out of the home to community/ social events etc.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual & Agency

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Supervision

Provider Category:

Individual ▾

Provider Type:

Individual & Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual demonstrating competency in supervision standards - Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07

Agencies - Enrolled QSP N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Transitional Living

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration

Category 2:

04 Day Services

Sub-Category 2:

04020 day habilitation

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Included is supervision, training, or assistance to the recipient with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living and mobility. Staff support including escort services is provided for supervision, independent living skills training until the interdisciplinary team determines this service is no longer appropriate.

Any eligible waiver recipient who needs these types of services can utilize transitional services. Transitional services are not limited to persons with a brain injury.

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

A program that provides training for the recipient to live with greater independence in his/her home or apartment. Transitional living will be provided under this waiver if it cost-effective and if necessary to avoid institutionalization.

This service is provided only until independent living skills development has been met or until the interdisciplinary team determines this service is no longer appropriate. If the individual is unable to achieve independent living skills and remains eligible for state and federal funded services the care plan is reviewed by the case manager and the individual to transition them from transitional care to a combination of state plan and waiver services such as personal care, homemaker, escort etc.

To avoid duplication homemaker, adult day care, adult foster care, residential care, and family personal care are not allowable service combinations for individuals receiving transitional care services. Transitional services cannot be provided at the same time as supervision.

Non-medical transportation to transport the client is allowed. Escort to accompany the individual while they are being transported is not allowed, as it is a component of transitional care services.

Pre approval from the Department of Human Services is required before this service can be authorized.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Transitional Living

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Experience providing services to individuals with a diagnosis of brain injury - Enrolled Qualified Service Provider N.D.A.C. 75-03-23-07

Verification of Provider Qualifications

Entity Responsible for Verification:

ND Medical Services Division

Frequency of Verification:

Initial/Re-enrollment every two years, and/or upon notification of agency status change

Appendix C: Participant Services

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

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

- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.

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

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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):

Criminal background checks are only completed for Adult Foster Care (AFC) and respite providers who provide care in an AFC home. Statutory authority to conduct background checks is limited to licensed AFC providers and respite workers who provide care in an AFC home.

AFC Providers are required to submit to both State and Federal background checks unless they have resided in the State continuously for eleven years or since reaching age 18, whichever is less; or if they are on active US military duty or have resided continuously in the State since receiving an honorable discharge.

N.D.C.C. 50-11 provides for nationwide, fingerprint based criminal background checks for AFC providers and their respite workers. The AFC licensure from the County Social Service Board monitors the need for a background check as part of AFC licensing. Staff from Aging Services Division receive and review the background check requests to assure all required information has been included. The background checks are submitted to the Bureau of Criminal Investigation for completion. Once the background check is complete the reports are returned to Aging Services. If the report indicates an offense the report is reviewed by an attorney from the Legal Service Division to ascertain whether the conviction will have an effect on the ability of that person to provide care in an AFC home as required in N.D.A.C. 75-03-21-09.1.

- 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):

For individual service providers the State Medicaid agency checks the - Board of nursing registry of licensed nurses and unlicensed assistive persons (UAP's) and Department of Health's Certified Nurse Assistant's and nurse aide registry; Attorney General's Sexual Offender's registry, ND State Court website, debarment database; excluded parties list system(EPLS), and the Department of Human Services HCBS provider complaint/termination database.

For agency service providers the State Medicaid agency checks the - debarment database;excluded parties list system (EPLS), and the Department of 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)

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

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

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.*

Legal spouses including (under certain circumstances) spouses who have decision making authority over their spouse may be paid to provide family personal care.

Payment may be made to a legally responsible person if the recipient chooses them as their provider and if the provider meets all of the required qualifications to enroll as a Qualified Service Provider for Family Personal Care. If the legally responsible person wants to become the provider and has decision making authority over the recipient the case manager must pre-approve the arrangement. The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency. The narrative must also be attached to the clients individual care plan when it is submitted to the State.

Extraordinary care consists of personal care or similar services and includes assistance with the ADL's/IADL's of bathing/ hygiene, dressing, incontinence care, toileting, transferring/positioning, mobility and feeding/eating. It also includes assistance with the tasks of eye care, medication assistance, cognitive supervision, exercise, Hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthetic orthotics, suppository/ bowel program, ted socks, vital signs, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage and specialty bed. Payment will not be made for assistance with the tasks of communication, community integration, housework, laundry, meal preparation, money management, shopping, social appropriateness, and transportation.

Once an individual or their legal representative selects a provider, they acknowledge on the care plan that they made an independent choice. In addition, the client is given a Client Rights and Responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

During client interviews, performed by the State Medicaid agency, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a client is not aware of their rights it is addressed with the case management entity and included as a finding on the review report. The case management entity is then required to provide a corrective action plan.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid Agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that the recipient's health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained the recipient.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that monitors them for compliance.

The cost of this service is limited to a maximum monthly cap set by the State Medicaid agency or through legislative action.

Payment for family personal care is only made to individuals who have individually enrolled as Qualified Service Providers with the State Medicaid office. These providers are required to submit claims via our North Dakota Medicaid Management Information System (MMIS). The MMIS system contains edits that would not pay a provider who is no longer enrolled or is not authorized to provide the service. The system also contains edits to assure that we are only paying the rate that was authorized. Payment is also limited to the services listed on the care plan. Every provider receives a copy of the authorization to provide services before they are eligible to provide the service. The authorization lists the allowable task, rate and service authorization period. Qualified Service Providers are required to maintain records and are subject to the provider review process.

- 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.

All providers including relatives and legal guardians are required to meet the same provider qualifications as all non relative providers. All providers are required to keep documentation and are subject to provider reviews.

- 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:

Any interested agency or individual may obtain a provider enrollment packet, upon request, from either the State Medicaid Agency or the County Social Service Board. In addition, during community presentations, the State offers the opportunity for interested entities to receive enrollment packets. Consumers inform the County or State of interested parties and enrollment packet(s) are distributed. Advocacy organizations have encouraged interested entities to request enrollment packets and the Department responds to inquiries from potential providers and generates contacts to potential providers. Provider enrollment handbooks are also available on the Department's website.

The State has revised the enrollment packets to streamline the process and documentation requirements. This process is periodically evaluated. The State produced a realistic job preview video that is available online and on DVD to help potential providers decide if providing direct care is right for them. Numerous provider educational opportunities have been provided Statewide they included information on how to enroll as a QSP.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

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

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

- i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:

Number and percent of licensed waiver providers that initially met provider licensing requirements for the type of waiver service they provide. N: Number of waiver providers who initially met provider licensing requirements. D: Total number of new waiver providers who are required to maintain a license.

Data Source (Select one):

Other

If 'Other' is selected, specify:

QSP enrollment records that require proof of a valid license be provided to the State Medicaid Agency before enrollment and reenrollment.

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):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (whichever comes first)	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (whichever comes first)

Performance Measure:

Number and percent of providers that continue to meet applicable licensure and/or certification standards following initial enrollment. N: Number of waiver providers who continue to meet applicable licensure and/or certification standards. D: Total number of waiver providers who are required to maintain licensure and/or certification standards.

Data Source (Select one):

Other

If 'Other' is selected, specify:

QSP enrollment records that require proof of a valid license be provided to the State Medicaid Agency before enrollment and re-enrollment.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (whichever comes first)	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (whichever comes first)

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 non-licensed/non-certified waiver providers who continue to meet waiver provider standards. N: number of enrolled non-licensed/non-certified waiver providers who continue to meet waiver provider standards. D: Total number of enrolled non-licensed/non-certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

QSP Enrollment Records/Database

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

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (whichever comes first)	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment every two years or upon expiration of required license (whichever comes first)

Performance Measure:

and % of reviewed clients where the QSP a) provided services as required by plan b) arrived and left as scheduled c) client's appearance/environment supported that the service was provided d) client's property was not taken or used e) client was treated respectfully f) client was not injured g) no rest. intervent./restraint was used. N:# of reviews where all assurances were met. D:# of client reviews.

Data Source (Select one):

On-site observations, interviews, 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):
	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 enrolled Qualified Service Providers (QSPs) that met the necessary provider training requirements for the type of waiver service they provide prior to furnishing waiver services. N: Number of waiver providers that met training requirements. D: Total number of Qualified Service Providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Qualified Service Provider enrollment 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and every two years thereafter	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and every two years thereafter

- 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 licensed and non-licensed providers must enroll as Qualified Service Providers (QSPs) before they can be reimbursed for providing waiver services. All providers are required to complete provider enrollment applications and submit documentation of applicable licenses etc. upon enrollment and re-enrollment. For example, Nurse Managers must provide proof of a valid nursing license to the State Medicaid Agency before enrollment and reenrollment. The State maintains a database that lists the provider’s enrollment date, expiration date, approved services etc. If a provider meets standards based on a license their enrollment date ends the same day as their license thus assuring they continually meet standards. Non-licensed providers are enrolled for no more than two years. QSPs are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a QSP. Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment. The state has two staff who are responsible to monitor all aspects of provider enrollment including closures, denials and terminations. The State measures how many providers’ meets standards by tracking enrollment rates, denials, and terminations.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient’s home as scheduled; c) The environment and recipient’s appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient’s needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient’s property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitors them for compliance.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 The State maintains a database that lists the provider’s enrollment date, expiration date, approved services etc. If a provider meets standards based on a license or certification their enrollment date ends the same day as their license thus assuring they continually meet standards. Non-licensed providers are enrolled for no more than two years or the end date on their documentation of competency whichever comes first. QSPs are notified two months prior to their expiration date that they must submit necessary documentation to maintain their status as a QSP. Providers who do not re-enroll are closed and edits are contained in the MMIS system to prevent closed providers from receiving payment. The state has two staff who are responsible to monitor all aspects of provider enrollment including closures, denials and terminations, training documentation etc. The State measures how many providers’ meets standards and training requirements by tracking enrollment rates, denials, and terminations. State staff will not enroll a provider who does not meet the State’s training requirements. In addition, when person-centered plans of care are submitted, State staff check to make sure that the providers on the plan are enrolled and approved to provide the listed services. If the provider is not enrolled the care plan is

denied and returned.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitor them for compliance.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and every two years thereafter

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.

Waiver services cannot exceed the amount equal to the highest monthly rate for the highest cost skilled nursing facility. This amount may be adjusted upon legislative action. Exceptions to the service limit will not be made. If the individual's needs cannot be met within the service limit the case manager will work with the client to explore other options including admittance to a skilled nursing facility or other program that can meet their needs. The case manager informs the participant of the service limit. If an individual's needs exceed the service limit they would be issued a denial notice and would have the right to appeal.

- 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, HCBS 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 (residential & nonresidential) where HCB services are provided to eligible clients. The analysis included review of ND Century Code, ND Administrative Code, HCBS policy, on site visits to all residential service providers, provider calls, and review of licensing rules, regulations and documentation.

Through this process the state has determined the following waiver services fully comply with the regulatory requirements because these services are individually provided in the recipient's private residence and allow the client full access to community living. Recipients get to choose what service and supports they want to receive and who provides them. Recipients are free to choose to seek employment and work in competitive settings, engage in community life and control their personal resources as they see fit.

Fully Complaint HCBS Waiver:

- Case Management
- Chore Services
- Emergency Response System
- Extended Personal Care/ Nurse Education
- Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-medical Transportation
- Respite Care
- Specialized Equipment and Supplies
- Transitional Living
- Environmental Modification
- Community Transition Services

The following waiver services are not provided in the individual's private residence but based on our analysis also fully comply.

- Institutional Respite: Short-term relief to full-time care givers provided in a nursing home or hospital - Comply per 42 CFR 441.301(c)(4)-(5):
- Supported employment fully complies because services can only be provided in competitive work settings. This service includes individualized training and is not conducted in a group setting. Receiving this service does not restrict a recipient's full access to community living. Waiver funds are not used to support employment in group homes, training centers or any setting that isolates individuals from the community. Recipients are free to seek competitive employment anywhere in the community and receive supports to sustain that employment. Recipients are free to engage in community life and control their personal resources as they see fit.

North Dakota received its initial systemic approval of its Statewide Transition Plan (STP) November 1, 2016. The State Medicaid agency will assure continued compliance with the HCBS settings rule by implementing and enforcing policy that will assure the continued integrity of the HCB characteristic that these services provide to waiver recipients. In addition, the State monitors all individual care plans, conducts case management reviews, client interviews/quality reviews to assure clients are free to choose what services and supports they wish to receive and who provides them.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Care 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:*

The State Medicaid agency allows entities to provide both case management and direct waiver services only when no other willing and qualified providers are available as a safeguard for potential clients that may live in rural areas of ND where access to qualified providers is an issue. The rural counties this applies to include: Adams, Barnes, Benson, Billings, Bottineau, Bowman, Burke, Cavalier, Dickey, Divide, Dunn, Eddy, Foster, Golden Valley, Grant, Griggs, Hettinger, Kidder, Lamoure, McLean, Mercer, Mountrail, Nelson, Oliver, Pembina, Pierce, Ramsey, Ransom, Renville, Richland, Sioux, Slope, Stark, Steele, Trail, Walsh, and Wells. If these agencies were restricted from providing both types of services it would likely create access issues for waiver recipients who live in these rural areas. The access issue for this waiver relates to case management providers and direct service workers. There are no private case management agencies enrolled as waiver providers. In some rural counties the only QSP agency is the local County Social Service agency. If these agencies were restricted from providing both services there would not be other providers available to provide the direct care.

Safeguards to ensure that service plan development is conducted in the best interest of the participant include:

Individuals or their legal representative choose their own qualified service provider (QSP) from a list provided to them or may recruit an individual who is willing to seek the designation as a QSP. The QSP list is updated by State office staff on a monthly basis and includes the following information: provider name and contact information, provider type, provider number, provider approved service(s) and applicable rates, and provider (approved) global endorsements. Individuals use the information on the list to make an informed decision. Clients initial on the care plan that they choose their own provider. Clients are provided with information that they have the right to choose their own provider during the person centered planning process.

Once an individual or their legal representative selects a provider they acknowledge on the care plan that they have also made an independent choice of services. The client signs a Client's Rights and Responsibilities form, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns directly to the State Medicaid agency. The form includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

During client interviews, performed by the State Medicaid agency, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a client is not aware of their rights the State Medicaid agency addresses the issue with the case management entity and includes it as a finding on the review report. The case management entity is then required to provide a corrective action 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. Annual Case management audits will include a record review that the same individual who provides case management is not also providing other HCB services.

Recipients are informed during the care plan meeting that if they have a dispute with the entity that provides their case management and direct services, they can contact the State directly to assist with a resolution. Recipients are provided with the State's toll free number and other contact information.

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.

Clients can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Comments, questions and statements are addressed to the recipient. Recipients are allowed to respond in their own words and at their own pace. The recipient input is considered to be the most important; other team members act as advisors. Meetings focus on strengths and goals of the recipient. Client's choose the service and provider and how much of the care plan to share with team members. If interpreters are needed, they are provided.

Case management is responsible to provide the client with information on the type of services available through various sources (paid & unpaid) including the waiver. Clients choose the service that they feel will most appropriately meet their needs. When a client chooses waiver services, the client or their legal representative signs the explanation of client choice form. Definitions of the services that are available under the waiver are included on the back of the form. The document informs the client or their legal representative that they have a choice of receiving the services listed on the individual care plan or to receive services in a nursing home. It also informs them of their right to consult with whomever they wish before making this decision including family, friends and advocacy organizations.

Individuals are given a copy of the Client Rights and Responsibilities brochure; it outlines client rights and responsibilities, and the case manager's responsibilities. The individual care plan is developed with the client and or their legal representative, case manager and anyone else the client chooses to include in the process. Once developed, the client or their legal representative signs that they are in agreement with the plan of care. The plan is also signed by individuals or entities responsible for implementing the plan. A copy or certain portions of the plan are provided to those individuals as directed by the recipient and or their legal representative.

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):

When an individual applies for services, the case manager initiates the person-centered planning process by scheduling a meeting with the client and or their legal representative and any other individual that the client wants involved in the process. Clients can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Care plans are developed for a six month time period. However, the client can request meetings and revise the plan at any time. Clients who have communication issues are provided auxiliary aides or interpreters who speak their primary language to facilitate their full participation in the planning process. Cultural preferences are acknowledged and accommodations are made when necessary.

The case manager conducts a comprehensive assessment. The comprehensive assessment includes the following elements: Cover sheet (assessment information, client identification, demographics, informal supports, legal representatives, emergency contacts, medical contact information, client stated goals, contingency plans (alternate

provider), health, welfare, and safety; Physical Health Information (nutrition, impairments, current health status, medication use, health risk factors); Cognitive/Emotional Status (cognitive behaviors, emotional wellbeing/mental health); Functional Assessment (activities of daily living, instrumental activities of daily living, supervised/structured environment/ special needs); Home Environment(physical environment, adaptive equipment/environmental modifications); Services/Economic Assistance Information (services/funding sources). This process also includes an assessment of the person's strengths and needs. Recipients are asked to describe their preferences, and goals are developed and documented in their own words including any desire for employment or alternative housing. Mechanisms for solving conflict and disagreement during the process are outlined during the meeting including discussing any conflict of interests.

Interim care plans may be developed for clients who require services immediately, or who are affected by natural disaster or other emergencies once Medicaid waiver eligibility has been determined, and the case management entity is not able to make a face-to-face visit on the day the service is requested. Interim care plans may also be used to ensure continuity of waiver services during a disaster or other emergency if the incident occurs at the time the annual service plan needs to be reviewed and updated and the case manager cannot make a face to face visit as required. Interim care plans can begin the day that the consumer is found to be eligible for waiver services, and cannot extend beyond the first 60 days of their annual care plan year, at which time the full comprehensive care plan must be implemented in order to continue the delivery and reimbursement of waiver services.

All contacts relating to the client must be noted in the narrative section of the comprehensive assessment. Information that must be contained in the note includes the date, reason for contact, location of the visits, a description of the exchange if face-to-face between the case manager and the client or collateral contact, description of clients environment, appearance, and communication style, a list of identified needs, service delivery options, summary of the agreed upon care plan, client stated goals, progress, or change in goals, client satisfaction, a statement about the adequacy of the services and whether or not the provider is providing the service in the amount, duration, and frequency expected. A follow-up plan addressing any issues must also be included in the narrative.

Participants are informed of home and community based services that are available in their communities (paid and unpaid) including services that are available under the waiver during the assessment process. On the individual care plan, the case manager lists other agencies and individuals who are providing services to waiver participants including informal supports. The individual care plan lists the type of service, provider's name, units of service authorized, the provider's rate and the total cost of care.

Participant goals and needs (including health care needs) are discussed during the assessment. Clients choose the type of service that will best meet their individual needs and choose who provides the care. All providers and services both paid and unpaid are listed. Client stated goals are documented on the individual care plan and reviewed at least every six months. The individual care plan reflects that the recipient chose the setting in which they reside and also includes a list of the person's strengths and positive attributes. The plan identifies potential risks and any approach that has been taken to mitigate those risks. Any deviation from helping the client to achieve their goals or assure their health and safety must be documented in the plan. The plan must include information on how safety needs were assessed based on the client's abilities and current condition as well as other interventions and methods that were tried first but were not successful. The plan must include documentation of a timeline for a periodic review of these modifications to determine if they are still necessary to assure health and safety. Recipients must be fully informed of the plan and any modifications made to their stated preferences or goals to assure safety. Documentation must be included to assure that the intervention will not cause harm to the recipient.

The case manager monitors the plan quarterly or more frequently if necessary to assure services are being delivered in the amount, scope and frequency stated in the care plan, and that progress toward desired goals is being met. Other individual or entities that are responsible for carrying out portions of the care plan are listed. Anyone involved in carrying out the plan must receive a copy of the plan or a portion of the plan as determined by the recipient. The care plan is updated on an annual basis and is reviewed at six months. Case managers are required to conduct quarterly face-to-face visits with the recipient. The recipient can choose the time and place of the care plan meeting which may include meetings after business hours or on weekends and they choose who participates. Case management activities may occur more frequently if applicable. Clients can request a meeting to discuss or modify the plan at any time. Clients are made aware of their responsibility to participate fully in the care plan process and its implementation.

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.

Through the comprehensive needs assessment, potential risks are identified. Including but not limited to risks related to financial concerns, legal issues, fire safety, falls, access to health care, family issues, informal/community/social supports, mental health/behavioral health needs, cognitive decision making, nutrition, medication, employment, education, and housing. The case manager and client will review the assessment results and develop a care plan to diminish risk. The individual care plan lists potential risks and any approach that has been taken to mitigate those risks. Any deviation from helping the client to achieve their goals or assure their health and safety must be documented in the plan. Case managers must include information on how the safety needs were assessed based on the client's abilities and current condition as well as other interventions and methods that were tried first but were not successful. The plan must include documentation of a periodic review of these modifications to determine if they are still necessary to assure health and safety. Recipients must be fully informed of the plan and any modifications made to their preferences or goals to assure safety. Documentation must be included to assure that the intervention will not cause harm to the recipient.

If a participant chooses an individual provider, the client and the case manager establish a contingency plan that is documented on the individual care plan. The contingency plan may include contacting another provider, family member, community resource, or if the service is not critical, rescheduling the service to be provided at another time. When individual providers enroll as Qualified Service Providers, they are required to state what they will do in the event that they are not able to provide the service as scheduled. If a participant chooses an agency provider it is the responsibility of that agency to send a replacement or if the service is not critical, to contact the client and reschedule.

Both individual and agency providers make assurances when they enroll with the State Medicaid Agency that they will contact the case managers when changes occur in the client's health status or service needs.

The State Medicaid agency conducts case management reviews, provider reviews, and client interviews to identify inappropriate service delivery or actions and to address the client needs and satisfaction with the services.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipients home as scheduled; c) The environment and recipients appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other restrictive interventions. Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance.

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.

A Qualified Service Providers (QSP) list is maintained by State office staff and distributed to case management entities on a monthly basis. A searchable public database is also available on the Department's website to assist individuals in finding a QSP. This list includes information about all providers who are currently enrolled to provide services and who choose to have their information shared with the public. The information contained in the QSP list includes: provider name and contact information, provider type, provider number, provider approved service(s), applicable rates, and provider (approved) global endorsements.

This list is shared with the clients so they can choose a provider and is used by the case managers to assure that providers are eligible to provide the type of service being authorized. The individual checks and signs the care plan indicating they were afforded the opportunity to choose their service provider(s). When requested, Case Managers may assist recipients in contacting providers to check their availability. Case managers may also advocate for the clients by contacting community providers who are not currently enrolled as Qualified Service Providers to see if they would be willing to enroll and serve waived recipients.

Case management entities are also informed of renewals, newly enrolled, and recently closed QSPs on a weekly basis thus assuring that clients have access to the most current list of providers available.

When a change in service provider occurs between case management contacts, the client or legal representative may contact the case manager requesting the change in provider and the contact is verified in the case manager's documentation. A copy of the updated person centered plan is sent to the client or legal representative.

Applicants/Clients may also recruit potential service providers. Case managers often help individuals identify family, friends, neighbors etc. that may be willing to provide care. The potential providers must comply with provider enrollment standards and requirements. If a potential provider is identified, the applicant may obtain a copy of the enrollment handbook at the local County Social Service office, or may print a copy from the Department's website.

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):

All person-centered plans are required to be forwarded to the State Medicaid Agency. An HCBS Program Administrator receives and reviews the care plans. Issues relating to inconsistencies or incompleteness are returned to the case management entity or individual for resolution. A copy of person-centered plan is available through an electronic file net system that is available to State Medicaid Agency staff.

The comprehensive assessments/narratives are also available through a web-enabled data system accessible to the Aging Services Division/HCBS staff.

These tools are used in case management reviews performed by the Department. The comprehensive assessment, individual care plans, authorizations, and other applicable information are used to determine services have been appropriately authorized by the case management entity.

The goal is to review all case management entities each year, either through an on-site or desk review. In addition, a statistically significant number of waiver assessments/care plans are reviewed via desk review by State Medicaid Agency staff. These reviews are conducted annually.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case management entity is responsible to monitor the person-centered plan and participant health and welfare. If the client's care needs cannot be met by the care plan and health, welfare and safety requirements cannot be assured; case management must initiate applicable changes or terminate Waiver services. If the case is closed, the client is made aware of their appeal rights.

The client's legal representatives, and family, also play a significant role in monitoring the care plan. The client or legal representative report changes to the case manager relating to the client's home, self, living arrangement, or service provision for care plan evaluation and revision.

Face to face contacts are required quarterly. At least one home visit is required during the needs assessment process. Case management contacts occur after 30 days (phone or face to face) from the initial care plan implementation and at least quarterly thereafter. Case management activities are not limited to quarterly contacts and additional contacts may be initiated when change is required in the care plan, a concern has been identified or at the request of the recipient.

The State monitors case management contacts. Each case management provider is required to document their billable case management tasks. Each case management provider is reviewed every year. A sample of the case managers files are reviewed and case management documentation is compared with billing history to assure compliance. If the case management documentation is not in compliance, case management fees are recouped.

Monitoring methods are determined by reviewing the care plan. Care planning is a process that begins with assessing the client's needs, goals and personal preferences. It includes the completion of the HCBS comprehensive assessment at which the case manager and client look at the needs and situations described in the comprehensive assessment and any other problems identified and work together to develop a plan for the client's care. All needs are identified in the comprehensive assessment and the services authorized to meet those needs are identified on the person centered plan of care plan. Additional information regarding needs and consumer choice is outlined in the narratives in the HCBS comprehensive assessment. For each functional impairment identified for which a service need has been authorized, a desired outcome and assistance required to achieve the outcome will be addressed in the notes/narrative section of the comprehensive assessment. For each ADL or IADL that is scored impaired and no waiver services have been authorized, the case manager documents how the need is being met. The case manager refers to the authorization to provide services form, to choose and discuss with the client the services and scope of the tasks that can be provided.

The HCBS case manager reviews with the client or the client's representative the following information about qualified service providers (QSPs) who are available to provide the service and who have the endorsements required to serve the client:

- Provider name and contact information
- Provider type
- Provider number
- Provider approved service(s)
- Applicable rates

The eligible provider selected by the client will be listed on the individual care plan. The service (paid & unpaid), amount of each service to be provided, the costs of providing the selected services, the specific time period, and the source(s) of payment are also recorded on the individual care plan, and the authorization to provide service.

Contingency planning must occur if the QSP selected is an individual rather than an agency. The backup provider or plan must be listed on the individual care plan. Agency providers are required to coordinate staff to assure service availability.

The case manager shall review with all clients or the client's representative the client stated goals. The goals must be recorded on the person centered plan of care, and described in the comprehensive assessment on an annual and six month basis. The final step in care planning is to review the completed individual care plan with the client /legally responsible party and obtain required agreements/acknowledgments and signatures.

The case manager assures that services are implemented and existing services continued, as identified in the individual care plan. This activity includes contacting the QSP and issuing an authorization for service(s) form.

Service monitoring is an important aspect of care planning and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The case manager monitors the client's progress/condition and the services provided to the client. As monitoring reveals new information to the case manager regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case manager shall document all service monitoring activities and findings in the client's case file. When completing monitoring tasks, if the case manager suspects a QSP or other individual is abusing, neglecting, or exploiting a recipient of HCBS, an established protocol must be followed.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the Medicaid agency the case managers conducts recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration and frequency as required by the care plan; b) Arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount outlined in the care plan; d) The services and amount of services meet the client's needs e) The available services meet the recipient's needs and assure that health, welfare and safety needs are met; e) The provider is not taking or using the recipient's property; f) The provider treats the recipient with respect; g) The provider has never injured the recipient; and h) The provider has never restrained or secluded the recipient or used other restrictive measures.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. The case manager reassesses the client, care plan, goals, and services on an ongoing basis, but must do a reassessment at six-month intervals and the comprehensive assessment annually. At the six-month and annual visit, the client stated goals must be reviewed and progress or continuation of the goals must be noted in the narrative of the comprehensive assessment.

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:*

Safeguards are in place to ensure that monitoring is conducted in the best interest of participants. The safeguards include the option for individuals or their legal representatives to choose a Qualified Service Provider (QSP) from a list provided to them or to recruit an individual who is willing to seek the designation as a QSP. Once an individual (or their legal representative) selects the provider of their choice, they acknowledge on the person centered plan that they made an independent choice of that provider. In addition, the client is given a Client's Rights and Responsibilities brochure, which clarifies that they have the right to choose a QSP, change a QSP and voice their complaints and concerns. The brochure includes the contact information for the case manager, the appeals supervisor, and the Executive Director of the Department of Human Services.

The State Medicaid agency conducts client interviews. Clients are asked if they were offered the opportunity to choose their service provider and asked if they were aware that they could change their service provider. If a provider is not aware of their rights, it is addressed with the case management entity and included as a finding on the review report. The case management entity is then required to provide a corrective action plan to the State Medicaid agency.

HCBS staff complete a review of each case management entity on an annual basis. If findings are identified corrective action plans are required. HCBS staff also review all individual care plans to assure that the client has acknowledge their choice of provider.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

Number and percent of waiver recipients face-to-face quality reviews to determine if individual's health, safety, and welfare needs are being addressed. N: Number of face-to-face quality reviews that determine individual's health, safety, and welfare needs are being addressed. D: Total number of face to face quality reviews.

Data Source (Select one):

On-site observations, interviews, 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify:	
	<input type="text"/> ^ v	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> ^ v

Performance Measure:

Number and percent of waiver recipients service plans that address all of the individual's goals. N: Number of service plans that address all of the individual's goals. D: Total number of service plans.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> ^ v
<input type="checkbox"/> Other Specify: <input type="text"/> ^ v	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> ^ v
		<input type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: All individual care plans are reviewed when they are received at the State Medicaid agency including initial ICPS, Modified ICPS and 6 month reassessments	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Every six months

Performance Measure:

Number and percent of assessment/care plans that: a) are complete and include all required information. b) include all four required contacts documented in the narrative c) include a list of approved services, provider's name and rate, units, and total cost of care. N: Number of assessments/participant plans that meet a, b, and c. D: Total number of plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Reviews will be completed the first and third year of the approved waiver	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Reviews will be completed the first and third year of the approved waiver. Reports will be compiled at that time.

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

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

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

- c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

Performance Measures

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

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

Performance Measure:

Number and percent of the participant plans that are updated annually. N: Number of participant plans updated annually. D: Total number of plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of the participant plans are updated when changes are warranted. N: Number of participant plans updated when changes are warranted. D: Total number of plans that warranted a change.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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:

Number and percent of client reviews that determined services are being delivered by the type, scope, amount, duration and frequency specified in the care plan. N: Number of client reviews that determined services are being delivered by the type, scope, amount, duration and frequency specified in the care plan D: Total number of client reviews.

Data Source (Select one):

On-site observations, interviews, 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	

		<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Reviews are completed the first and third year of the renewed waiver.	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Reviews are completed the first and third year of the renewed waiver. Reports/data will be compiled at that time.

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.

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The State will complete desk reviews of a statistically significant number of HCBS waiver recipient's assessments/care plans during the first and third year of the waiver to determine if needs have been assessed according to policy and procedures. The State will also review 100% of the HCBS waiver files to determine if they have a current care plan.

Statistical significance for the desk review of assessments/care plans will be determined by calculating a representative random sample of current waiver recipients based on credible parameters including a 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution. The state will use a research number randomizer to choose which waiver cases to review.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitor them for compliance.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

State Medicaid Agency staff are responsible for addressing individual problems regarding care plans. Remediation techniques include but are not limited to providing one on one technical assistance, group training, adding information to the case management update that is emailed to all case managers, issuing corrective actions including the submission of missing or incomplete information, and recoupment of funds and or case management fees if necessary.

Problems identified during the quality review must either identify a remediation plan and/or must be reported to the State as a complaint. State Medicaid Agency staff are responsible for addressing all complaints. The State maintains a complaint database to track complaints by the date the complaint was received and responded to, and by type and resolution. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Case reviews will be conducted of a statistically valid number of waiver files during the first and third year of the renewed waiver. Reports will be compiled after each of those reviews.

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.

An applicant requesting Home & Community Based Waiver services completes an application form. The application form contains information pertaining to consumer rights and explains the procedure 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 consumer or their legal representative.

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

On the individual care plan the client must check both: I am in agreement with the services and selected the service providers listed above and I am in agreement with this plan. If either of these two acknowledgments are not checked and signed by the client or the client's legal representative the client or the legal representative must be given a completed termination, denial or reduction form to inform the client of their right to a fair hearing. The form includes contact information for the appeals supervisor. The care plan is signed and dated by the client or the legal representative at least every six months.

When an applicant/client is denied HCBS or if their services have been terminated or reduced, they are provided with the SFN 1647 HCBS Notice of Denial, Termination or Reduction form. If an applicant/client services are reduced, denied or terminated, they are informed of the timeline necessary to submit an appeal. Waiver recipients are also notified via the SFN 1647 that if a Medicaid appeal is received before the date of the termination is effective, services can continue until a hearing decision has been made. If the State Medicaid agencies decision is upheld, the client will be required to reimburse the State Medicaid agency for services provided after the termination date.

Copies of all SFN 1647 forms are kept in the clients file.

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:

The State Medicaid agency uses a multi-disciplinary team approach if a complaint/grievance is received. When an HCBS Administrator receives a complaint, staff will assess the situation and arrange a team consult if needed.

At times, the team will be comprised of other HCBS team members, Medical Services Administration Unit Staff, Case Managers, Vulnerable Adult Protective Services, Health Department, Protection & Advocacy, and Long Term Care Ombudsman. Others may be involved depending on the situation.

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

The Department accepts any complaint received. When a participant notifies the State Medicaid agency of a grievance or complaint, the complaint is received, evaluated, applicable records relating to the complaint are reviewed, collateral information is obtained from the involved persons, and resolution is sought. If the complaint identifies immediate risk or harm to the client, law enforcement is involved as appropriate. Other complaints are responded to based on severity or within 14 days. If the complaint is related to a denial / reduction / or termination of services, the client is informed that this process is not a pre-requisite or substitute for a fair hearing.

A tracking system is maintained of the complaints, type of complaint, and the resolution.

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).

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

Reportable incidents include:

- Abuse, neglect, or exploitation;
- Rights violations through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation, or policy;
- Serious injury or medical emergency, which would not be routinely provided by a primary care provider;
- Wandering or elopement;
- Restraint violations;
- Death of a waiver recipient and cause;
- Report of all medication errors or omissions; and
- Any event that has the potential to jeopardize the waiver recipient's health, safety or security if left uncorrected.

All reports must be filed within five (5) days of the incident.

The State of North Dakota has a mandatory reporting law for reporting suspected abuse or neglect of an adult. The law requires certain professions including qualified service providers, nurses, nursing home personnel, hospital personnel, occupational therapists, physical therapists, physicians, social workers and other to report abuse, neglect, and exploitation of vulnerable adults. Any other person may voluntarily report to the ND Department of Human Services or to law enforcement. A mandated reporter must report if in an official or professional capacity, he or she:

- Has knowledge that a vulnerable adult has been subjected to abuse or neglect; or
- Observes a vulnerable adult being subjected to conditions or circumstances that reasonable would result in abuse or neglect.
- Mandatory reporters are required to report as soon as possible.
- Any person required to report who willfully fails to do so is guilty of an infraction and subject to a fine of up to \$1,000.

Reports are submitted using a standardized online reporting tool or phone call with a central intake staff member. Guidelines and flow charts have been developed to help reporters know where to send their information and

what type of information should be included. The Department of Human Services distributed information about the mandatory reporting law to all QSPs including those that provide care to waiver recipients and has done outreach and training to make people aware of this new law.

The State Medicaid agency has written policies detailing the process of monitoring for abuse, neglect, or exploitation of all waiver participants. Policy states that the case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the State Medicaid agency. When case managers become aware of an incident, State law and policy requires that they gather specific information and report it to the appropriate party.

Incidents may include abuse, neglect, or exploitation. Abuse means the willful act or omission of a caregiver or any other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation to or of a vulnerable adult. Neglect means the failure of a caregiver to provide essential services necessary to maintain physical and mental health of a vulnerable adult; or the inability or lack of desire of the vulnerable adult to provide essential services necessary to maintain and safeguard the vulnerable adult's own physical and mental health. Exploitation is the act or process of an individual using the income, assets, or person of a resident for monetary or personal benefit, profit, gain, or gratification.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported. Incidents involving unauthorized use of restraints must be reported per the requirements listed in Section G-2-a-i.

In addition to the mandatory report to the Department of Human Services and depending on the situation, the case management entity could also potentially report the incidents or suspicions to tribal entities, State Regional Human Service Centers, Vulnerable Adults Protective Services, Long Term Care Ombudsman, Health Department, Protection and Advocacy, law enforcement, and/or the State Medicaid agency. In addition these same entities report suspected abuse, neglect, or exploitation of waiver participants to case management entities and or the State. This sharing of information helps to assure the timely resolution of concerns.

In between formal contacts by the case manager clients are made aware that they can contact the case manager to report any concerns. During client interviews conducted by the State Medicaid agency staff, clients are asked if they know the name of their case manager and how to reach that individual. This helps to assure that the client will know whom to call to report an incident when one occurs instead of waiting until the case manager contacts them. In addition, family, friends, advocacy groups and other service providers report complaints to the case managers and or the State Medicaid agency.

Providers are subject to the mandatory reporting law and agree when they enroll to report potential abuse or exploitation when they become aware of the incident to the case manager.

Clients are provided with a copy of the client rights and responsibilities form. The form contains contact information for the case manager, appeal supervisor and the Executive Director of the Department of Human Services. Clients may contact either of these individuals or the State Medicaid agency to report an incident that involves the nurse or case management. If a complaint is received in regard to a nurse or case management entity State Medicaid office staff work with the case managers supervisor and others to resolve the situation.

Substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, arrest by law enforcement. If allegations are found to be unsubstantiated, the complaint is logged in the complaint database and no further action is taken.

The information is typically received via telephone or e-mail. However, information can also be obtained from letters, face-to-face contact, the review process, or through general discovery.

The HCBS Case Manager is required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid Agency, the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's

property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including restraint.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who monitor them for compliance.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid Agency per policy. These conditions or practices must be abated or eliminated immediately or if applicable within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error within five days of the incident. The State Medicaid Agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

- 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.

The clients, or their legal representatives, will receive a Client's Rights and Responsibilities form describing their rights and their responsibility to self-report when they are approved for services. Case managers list their name and contact information for the case management entity on the form. Case Managers are required to have quarterly face to face contact with all waiver recipients. One of those visits is used to conduct an annual quality review where clients are asked specific questions about potential abuse, neglect, exploitation and have a conversation about the quality of their care. During all other contacts case managers are also required to discuss any issues the clients may be having with their care and address and follow up on all problems identified.

- 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 Department of Human Services receives all mandatory reports of suspected abuse, neglect or exploitation of a vulnerable adult. According to North Dakota Century Code 50-25.2-03 (4), a report shall be made "as soon as possible". If a mandatory report investigation determines that the vulnerable adult is a waiver recipient or if the allegation involves a qualified service provide the State Medicaid Agency is also notified. Case managers are also required to provide a report of abuse, neglect or exploitation to the State Medicaid agency if the vulnerable adult in the situation involves a recipient or qualified service provider. The HCBS staff person follows through by working with the case manager to assist with the investigation of the complaint or concern identified. Depending upon the incident, there are several entities that are alerted about the allegations. If the accused person is not a provider, the complaint is referred to the Vulnerable Adults Protective Services for resolution. If the accused is a provider the HCBS program staff person works with the case manager and determines a resolution. If the case involves an individual with Developmental Disabilities the DD Division and Protection and Advocacy are contacted for resolution. If the case involves Adult Foster Care (AFC) clients the licensing agents responsible for AFC licensing are contacted for resolution. If the case involves a client residing in a Basic Care or Assisted Living Facility the Long Term Care Ombudsman is contacted for resolution and depending on the concern, the North Dakota Department of Health or the Departments Agent responsible for Assisted Living Licensure may be involved. If the complaint presents an imminent risk, or potential criminal activity is suspected, law enforcement is immediately contacted by the case manager.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency per policy. These conditions or practices must be abated or eliminated immediately or if applicable within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error within 5 days of the incident. The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

In addition, the nurse who provides the training for attendant care services is required to maintain records related to: (1) the nursing activities that were taught to the attendant care provider and written instructions for the required tasks, (2) the re-evaluation of the client's needs through an annual nursing assessment and any additional need for training of the attendant care provider (3) incidents that result in client injury or require medical care. The nurse must also provide written documentation to the State Medicaid agency that shows he or she has provided instructions to the attendant provider that outlines the types of situations that are considered reportable incidents. Attendant providers must also immediately report incidents that result in client injury or require medical care to the client's primary care provider. If the HCBS case manager and State Medicaid agency staff determine that the incident is indicative of abuse, neglect, or exploitation, the appropriate protocol for abuse neglect resolution will be followed.

If a complaint involves the provision of home delivered meals Aging Services Division, Department of Health or United States Department of Agriculture (USDA) would be contacted depending on whether the provider was a hospital, nursing home, basic care facility, OAA nutrition provider, ND licensed food establishment or facility regulated by the USDA.

If a complaint involves a case manager, State Medicaid Agency staff are responsible to investigate the incident and may involve the case manager's supervisor and other entities as appropriate.

Policy dictates that case managers immediately report suspected physical abuse or criminal activity to law enforcement. The incident must also be reported to the State Medicaid agency. Response time to all other complaints and concerns are responded to within 14 days.

The incident could result in continued monitoring, termination of providers, removal of client(s) from residences, arrest by law enforcement, or if allegations are not supported, it is considered unsubstantiated. When appropriate, either the case manager or the State Medicaid agency will inform interested parties including the client or responsible party of the resolution of the complaint.

The State Medicaid Agency may require the provider to submit a written plan to abate or eliminate immediately, or within a fixed period of time the practices or conditions that resulted in the incident.

- 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.

In addition to the information supplied in the previous sections, the State Medicaid agency may also conduct on-site reviews of a service provider or on-site client interviews if there is an allegation of a critical incident.

If the incident involves the assistance of Protection and Advocacy, the Health Department, a Department of Human Services Long Term Care Ombudsman, HCBS Administration Unit or Medical Services, the State will contact these individuals for assistance in the assessment/evaluation of the allegation. These various entities would then determine if separate on-site investigations should occur.

Case Managers are required to submit the results of the quality reviews conducted with waiver recipient's to the State Medicaid agency who will monitor them for compliance. If an immediate threat to the recipient is identified case managers will be required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported and will be responded to per the complaint policy.

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers are required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency per policy. Conditions or practices that are adversely affecting the provision of medication administration must be abated or eliminated immediately or if applicable within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error within 5 days of the incident. The State Medicaid agency will review medication error reports for compliance and corrective efforts.

If an allegation involves the case manager the State Medicaid agency is responsible to respond to the complaint. The State Medicaid agency may involve the case manager's supervisor, social service board or other interested parties as appropriate.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

- The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The use of restraints is only permitted during the course of the delivery of Adult Residential Services. Restraints may not be used in any other setting where waiver services are provided. Adult Residential Service facilities must be licensed as Basic Care facilities in accordance with ND Admin Code 33-03-24.1-03. Adult Residential facilities must act in accordance with resident rights which comply with NDCC 50-10.2 and ND Admin Code 33-03-24.1-09 (2) (h). NDCC 50-10.2-02 (1) (k) states that residents have "The right to be free from mental and physical abuse and the right to be free from physical or chemical restraint except in documented emergencies or when necessary to protect the resident from injury to self or to others". Administrative code also dictates that any use of restraints must be authorized and documented by a physician for a limited period of time and, if the restraint is a chemical one, it must be administered by a licensed nurse or physician. Except as provided in this subdivision, drugs or physical restraints may not be used or threatened to be used for the purposes of punishment, for the convenience of staff, for behavior conditioning, as a substitute for rehabilitation or treatment, or for any other purpose not part of an approved treatment plan.

Before restrictive emergency procedures can be implemented as described in the administrative code it is the responsibility of the case manager to assess and document the restriction plan on the person-centered plan of care. This plan is reviewed quarterly. The case manager will document the maladaptive behavior and the identified restriction. Less restrictive methods must be included in the plan and attempted prior to the application of restraint. Previous restriction plans must be identified in the plan. The emergency use of restraints must be developed with the participation of the waiver recipient and/or their legal decision maker who must consent to the plan. The HCBS Program Administrator reviews all plan of care and will approve the plan of care if it contains all of the required information.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported. Some Adult Residential facilities have a no-restraint policy if a recipient chooses such a facility it will be documented in the plan of care.

- 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:

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported.

The use of all unauthorized restraints (those not written into the individual's plan, or those that do not follow the requirement of NDCC 50-10.2-02 (1) (k)), must be abated or eliminated immediately and meet the criteria of a Serious Event. These situations must be verbally reported to the HCBS Case Manager and Aging Services immediately. A incident report must also be submitted in writing to Aging Services within 24 hours of the incident. The Aging Services Team will review all incident reports to determine if restraints were used appropriately. If it is determined that restraints were used appropriately it will be documented in the recipient's narrative. If it is determined restraints were not used appropriately, and in accordance with state law, a formal referral to VAPS and/or ND Department of Health (licensing entity) will be initiated. VAPS and/or ND Department of Health will be responsible for independent review and follow up.

The Aging Services Team consists of the Aging Services Director, HCBS Program Administrator, Aging Services Program Administrator licensed as an RN, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the HCBS Case Manager. The HCBS Case Manager must also review the plan of care on a quarterly basis to assure the safeguards and requirements are met and to assure that the approval of the individual and/or legal decision maker is documented. This information is recorded in the narrative and any noncompliance or needed follow up regarding the use of restraints are initiated and documented.

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 ND Department of Human Services and the Department of Health monitor the use of restrictive interventions in residential facilities and through Adult Foster Care licensing. The Department of Health monitors the use of any type of restrictive interventions in adult residential settings through a survey process. In addition, the State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of restrictive interventions is considered to be 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. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

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:

The ND Department of Human Services and the Department of Health monitor the use of seclusion in residential facilities and through Adult Foster Care licensing. The Department of Health monitors the use of any type of seclusion in adult residential settings through a survey process. In addition, the State Medicaid agency conducts client interviews. During the client interview participants are asked if the provider is respectful to the client, conscientious with their property and if the completed tasks meet their expectations. These questions allow the client an opportunity to discuss any concerns about the way the care is provided or how their provider treats them.

The use of seclusion is considered to be part of the definition of abuse. Therefore, case managers are also responsible to report the use of seclusion as a part of the monitoring process to assure health, welfare and safety. In addition, providers have signed agreements stating that they will report suspected abuse or exploitations of waiver participants to the case manager.

HCBS Case Managers are required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never restrained or secluded the recipient or used other types of restrictive interventions.

Case Managers are required to submit the results of the quality review to the State Medicaid agency that will monitor them for compliance. If an immediate threat to the recipient is identified case managers are required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy and the mandatory reporting law.

- 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.

- Basic Care Facilities that provide Adult Residential Services have ongoing responsibility for medication regimen based on their Basic Care Licensure. Each Basic Care facility is licensed annually by the Department of Health, Division of Health Facilities. Unannounced onsite surveys are conducted each year on approximately 1/3 of the Basic Care Facilities. Complaints are received by the Division in any form, and are investigated by unannounced onsite visits. When non-compliance is identified the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all five components of a plan of correction are represented in the plan. Revisits are conducted on all citations to verify implementation of the plan of correction and that the implementation has indeed corrected the problems identified. All Basic Care facilities are surveyed ever two years for compliance to life safety code requirements.

Basic Care survey process consists of several tasks, Sub-Task 5E - Medication Pass – deals with medication management. The medication pass portion of the survey is described below.

Sub-Task 5E – Medication Pass: A. General objective is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice. B. General Procedures: Record observations and the physician's actual order. When observing the medication pass, do the following: Be as neutral and unobtrusive as possible; Observe a minimum of 10 opportunities for errors; Strive to observe as least two individuals administering medications; Ask the person administering the medication if they know what the medication is and what it does and how the person was trained. Verify the training and competency of the person who administered the medications.

- There is an enforcement process that can be applied to basic care facilities that are unwilling or unable to achieve and maintain compliance. Facilities are subject to one or more enforcement actions, which include: A ban or limitation on admissions, suspension or revocation of a license or a denial to license, for the following reasons:(1).Noncompliance with the requirements of this chapter have been identified which:(a) Present imminent danger to residents.(These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department);(b) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or (c) Have a potential for jeopardizing resident health, safety, or

security if left uncorrected.

- Swing bed facilities that provide respite care have ongoing responsibility for medication regimen based on their licensure as a hospital.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification compliance. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health. Hospital swing bed facilities must follow the hospital or Critical Access Hospital (CAH) conditions of participation in addition to swing bed requirements. Onsite surveys are conducted based on criteria set by the Centers for Medicare and Medicaid Services (CMS). All surveys, including complaints, are conducted without announcing the survey to the facility.

Hospital survey process consists of several tasks: Task 1 – Offsite Survey Preparation; Task 2 – Entrance Activities Task 3 – Information Gathering/Investigation; Task 4 – Preliminary Decision Making and Analysis of Findings; Task 5 – Exit Conference

Task 6 – Post Survey Activities. All surveys include record review, interviews and observation of care and services provided.

When non-compliance is identified, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed and determined acceptable only after all components of a plan of correction are represented in the plan. Revisits are conducted on all deficiencies to verify implementation of the plan of correction and that the implementation has corrected the problems identified.

- Nursing Facilities that provide respite services have ongoing responsibility for medication regimen based on their Nursing Facility Licensure. Each skilled nursing facility is required to be surveyed annually for compliance to the federal Medicare and Medicaid certification regulations. During the annual survey, Sub -task 5E is conducted as part of the routine survey process. Sub -task 5E is the medication pass determination for compliance and an explanation of the task is written below.

Sub-Task 5E - Medication Pass and Pharmacy Services:

A. Objectives: To determine whether the facility safely administers medications including: Accuracy of medication administration; Labeling that contains at least the name and strength/concentration of the medication, as well as expiration date when applicable, Security of medications to determine: whether medications are stored and handled in accordance with manufacturers' recommendations and/or state or federal requirements; whether the facility reconciles controlled medications, as appropriate; whether the facility obtains the services of a licensed pharmacist; and whether the facility provides or obtains pharmaceutical services, including routine and emergency medications, to meet the needs of each resident.

B. Use: The medication pass and a review of storage and access to medications must be conducted on every Initial and Standard survey; and Revisits, as necessary; Review for the provision of licensed pharmacist consultation on the initial survey and on any other survey type, if the survey team has identified concerns that indicate: That the facility does not have a licensed pharmacist; and/or that the licensed pharmacist may not have performed his/her functions related to the provision of pharmaceutical services; Review for the development and implementation of pharmaceutical procedures if, concerns have been identified regarding: the availability of medications; accurate and timely medication acquisition; receiving, dispensing, administering, labeling, and storage of medications; reconciliation of controlled medications; and the use of qualified, authorized personnel to handle and dispense medications.

C. General Procedures

1. Medication Pass (includes labeling): When observing the medication pass: Be as neutral and unobtrusive as possible; Observe different routes and/or forms of medications; Initially observe the administration at least 20-25 medications; Record, from the medication label, the name and dose/concentration of each medication administered. Also record the route of administration (if other than oral) and the expiration date, if expired; Record all multiples, For liquids, record actual volume, or in the case of items such as psyllium, record number of "rounded teaspoonfuls" and the amount of liquid; Observe whether staff confirmed the resident's identity prior to giving medications and whether the medications were identified up to the point of administration. Record the techniques and procedures that staff used to handle and administer medications; and observe whether staff immediately documented the administration and/or refusal of the medication after the administration or the attempt.

After the medication pass, compare your observations with the prescriber's orders. Determine whether there was

an error(s) in medication administration i.e. an error in the preparation or administration of medications or biologicals that is not in accordance with any of the following: The prescriber's order; Manufacturer's specifications regarding the preparation and administration of the medication or biological; Accepted professional standards and principles that apply to professionals providing services.

After completion of the observations and reconciliations, calculate the facility's medication error rate, if one or more errors are found. If it is determined that the facility's overall error rate is 5 percent or more, a medication error deficiency exists.

2. Medication Storage (includes labeling): Review medication storage in order to determine whether: Medications and biologicals are accessible only to authorized staff and are locked when not under the direct observation of the authorized staff; Controlled medications are stored in a manner to limit access and to facilitate reconciliation in accordance with the facility policies; Medications are stored to maintain their integrity and to support safe administration of the correct medication to the correct resident, by the correct route and in the correct dose; Medications are not expired, contaminated, or unusable; Medication labels are legible; intact; contain the name and dose/concentration of the medication, appropriate cautionary/accessory instructions, expiration date, and support the safe administration of the medication; and Multi-dose vials are labeled per facility policy and manufacturer's specifications once use of the vial has been initiated.

3. Controlled Medications: If a concern regarding controlled medications was identified during the survey process or during the medication pass, interview facility staff, regarding the concern. If a potential problem has been identified regarding lack of reconciliation or loss of controlled medications: Determine whether Scheduled II controlled medications are in separately locked, permanently affixed compartments (or are a minimal amount of unit dose packages); Review the facility procedure and a sample of the reconciliation records, and compare the amount of medication available with the amount the records indicate should be available; and interview the director of nursing and/or licensed pharmacist regarding: Actual frequency of the reconciliation; How the facility investigates loss or inability to reconcile controlled medications; and How the licensed pharmacist has been involved in recognizing the situation and collaborating with the facility to review and update its practices and procedures.

4. Pharmaceutical Services: If concerns have been identified regarding pharmaceutical services, review the facility's evidence that they have been receiving ongoing pharmacy consultation regarding all aspects of the provision of pharmaceutical services in the facility. Determine whether the licensed pharmacist is available during the survey or identify how to contact the licensed pharmacist; Review procedures and interview staff regarding the areas of concern.

5. Provision of a Licensed Pharmacist: If there is no licensed pharmacist providing services in the facility, interview the administrator and others, as appropriate, regarding: The length of time the facility has been without the services of a licensed pharmacist; and current efforts underway to obtain the services of a licensed pharmacist.

- 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.

North Dakota Department of Health is responsible for oversight of Basic Care Facilities.

Sub-Task 5E – Medication Pass

A. General Objective

The general objective of the medication pass is to observe the actual preparation and administration of medications in order to assess compliance with acceptable professional standards of practice. B. General Procedures Record observations. Record the physician's actual order. Do this only if the physician's order differs from the observation of the administration of the drug. When observing the medication pass, do the following:

- Be as neutral and unobtrusive as possible during the medication pass observation.
- Observe a minimum of 10 opportunities for errors (opportunities are both the drugs being administered and the

doses ordered but not administered). Strive to observe at least two individuals administering medications if possible. This provides a better overall picture of the accuracy of the facility's entire drug distribution system. Ask the person administering the medication if they know what the medication is and what it does. Ask how the person was trained to administer medication. Ideally, the medication observation could include residents' representative of the care needs in the sample. This would provide additional information on these residents, and provide a more complete picture of the care they actually receive. For example, if blood sugars are a problem, insulin administration may be observed. If eye infections are a problem, antibiotic eye drops may be observed, if residents are in pain, as needed pain medications may be observed, etc. Observe different routes of administration, i.e., eye drops, injections, inhalation. The opportunities should equal 50% of the resident census, not to exceed 40 opportunities.

- Verify the training and competency of the person who administered the medications.

- There is an enforcement process that can be applied to basic care facilities that are unwilling or unable to achieve and maintain compliance. Facilities are subject to one or more enforcement actions, which include: A ban or limitation on admissions, suspension or revocation of a license, or a denial to license, for the following reasons:

(1). Noncompliance with the requirements of this chapter have been identified which:

- (a) Present imminent danger to residents. These conditions or practices must be abated or eliminated immediately or within a fixed period of time as specified by the department;
- (b) Have a direct or immediate negative relationship to the health, safety, or security of the residents; or
- (c) Have a potential for jeopardizing resident health, safety, or security if left uncorrected.

The North Dakota Department of Health is responsible for the oversight of hospital swing bed facilities.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Swing bed facilities must follow the hospital or CAH conditions of participation in addition to swing bed requirements.

All surveys are conducted using an outcome oriented survey process and include record review, interview and observation.

The Hospital Conditions of Participation require pharmaceutical services meet the needs of the patients' by promoting a safe medication use process that ensures optimal selection of medications, dose, dosage form, frequency, route, duration and that substantially reduces or eliminates adverse drug events and duplication of treatment.

The Critical Access Hospital Conditions of Participation also require rules for storage, handling, dispensation and administration of drugs and biologicals. The CAH must ensure the safe and appropriate use of medications and medication-related devices.

Hospital licensing rules require compliance with the pharmacy requirements. When non-compliance is identified by survey staff, the facility is required to write a plan of correction to address the cited issue. The plan is reviewed by survey staff and determined acceptable only after all components of a plan of correction are represented in the plan.

Revisits are conducted on all citations to verify implementation of the plan of correction and that the implementation has corrected the problems identified.

The North Dakota Department of Health is responsible for the oversight of nursing facilities.

- Nursing Facilities that provide respite services have ongoing responsibility for medication regimen based on their Nursing Facility Licensure. Each skilled nursing facility is required to be surveyed annually for compliance to the federal Medicare and Medicaid certification regulations. All surveys are unannounced. During the annual survey, Sub -task 5E is conducted as part of the routine survey process. Sub -task 5E is the medication pass and pharmacy services determination for compliance and an explanation of the task is written below.

Sub-Task 5E - Medication Pass and Pharmacy Services:

General Procedures

1. Medication Pass (includes labeling): When observing the medication pass: Be as neutral and unobtrusive as possible; Observe different routes and/or forms of medications; Initially observe the administration at least 20-25 medications; Record, from the medication label, the name and dose/concentration of each medication administered. Also record the route of administration (if other than oral) and the expiration date, if expired; Record all multiples, For liquids, record actual volume, or in the case of items such as psyllium, record number of "rounded teaspoonfuls" and the amount of liquid; Observe whether staff confirmed the resident's identity prior to giving medications and whether the medications were identified up to the point of administration. Record the techniques and procedures that staff used to handle and administer medications; and observe whether staff immediately documented the administration and/or refusal of the medication after the administration or the attempt.

After the medication pass, compare your observations with the prescriber's orders. Determine whether there was an error(s) in medication administration i.e. an error in the preparation or administration of medications or biologicals that is not in accordance with any of the following: The prescriber's order; Manufacturer's specifications regarding the preparation and administration of the medication or biological; Accepted professional standards and principles that apply to professionals providing services.

After completion of the observations and reconciliations, calculate the facility's medication error rate, if one or more errors are found. If it is determined that the facility's overall error rate is 5 percent or more, a medication error deficiency exists.

2. Medication Storage (includes labeling): Review medication storage in order to determine whether: Medications and biologicals are accessible only to authorized staff and are locked when not under the direct observation of the authorized staff; Controlled medications are stored in a manner to limit access and to facilitate reconciliation in accordance with the facility policies; Medications are stored to maintain their integrity and to support safe administration of the correct medication to the correct resident, by the correct route and in the correct dose; Medications are not expired, contaminated, or unusable; Medication labels are legible; intact; contain the name and dose/concentration of the medication, appropriate cautionary/accessory instructions, expiration date, and support the safe administration of the medication; and Multi-dose vials are labeled per facility policy and manufacturer's specifications once use of the vial has been initiated.

3. Controlled Medications: If a concern regarding controlled medications was identified during the survey process or during the medication pass, interview facility staff, regarding the concern. If a potential problem has been identified regarding lack of reconciliation or loss of controlled medications: Determine whether Scheduled II controlled medications are in separately locked, permanently affixed compartments (or are a minimal amount of unit dose packages); Review the facility procedure and a sample of the reconciliation records, and compare the amount of medication available with the amount the records indicate should be available; and interview the director of nursing and/or licensed pharmacist regarding: Actual frequency of the reconciliation; How the facility investigates loss or inability to reconcile controlled medications; and How the licensed pharmacist has been involved in recognizing the situation and collaborating with the facility to review and update its practices and procedures.

4. Pharmaceutical Services: If concerns have been identified regarding pharmaceutical services, review the facility's evidence that they have been receiving ongoing pharmacy consultation regarding all aspects of the provision of pharmaceutical services in the facility. Determine whether the licensed pharmacist is available during the survey or identify how to contact the licensed pharmacist; Review procedures and interview staff regarding the areas of concern.

5. Provision of a Licensed Pharmacist: If there is no licensed pharmacist providing services in the facility, interview the administrator and others, as appropriate, regarding: The length of time the facility has been without the services of a licensed pharmacist; and current efforts underway to obtain the services of a licensed pharmacist.

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements at 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. To certify a SNF or NF, at least a: 1. Life Safety Code (LSC) survey; and 2. Standard Survey must be completed. All citations are revisited, the revisit may be onsite or it may be by mail and/or phone.

-Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:

- A) Result in imminent danger to the health, safety or security of the waiver recipient;
- B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
- C) Result in the hospitalization of the recipient;
- D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately or within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error to the State Medicaid agency within 5 days of the incident.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable. *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)***

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

With the exception of extended personal care, adult residential and respite care provided in a basic care, swing bed or nursing facility, N.D.A.C. 75-03-23-07 and the Qualified Service Provider handbook outline the standard for self-administration of medication. A definition of self-administration is located on back of the SFN 1699 Authorization to Provide Service form that is given to a provider prior to the implementation of service provision. The definition on the back of the form reads, medication assistance is limited to assisting with client self-administration of routine oral medications by doing the following: opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container.

Information about medication errors concerning medication administration that is authorized as part of a waived service will be communicated to the State Medicaid agency in the following manner:

- Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:

- A) Result in imminent danger to the health, safety or security of the waiver recipient;
- B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
- C) Result in the hospitalization of the recipient;
- D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately or within a fixed period of time as outlined by the basic care, swing bed or nursing home facility licensing requirements. Providers must report the error to the State Medicaid agency within 5 days of the incident.

- Qualified Service Providers that are authorized to provide medication administration to waiver recipients i.e. extended personal care, and nurse education providers will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:

- A) Result in imminent danger to the health, safety or security of the waiver recipient;

- B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
- C) Result in the hospitalization of the recipient;
- D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately and reported to the recipient's primary care physician and the Case Manager who will contact the State Medicaid agency. The State Medicaid agency must be contacted within 5 days of the incident.

In addition, a nurse educates the extended personal care service provider about medication administration for a specific client. This activity is governed under N.D.A.C. 55-05-04 of the Nurse Practice Act.

The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

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:

Qualified Service Providers that have 24 hour responsibility for the medication administration of waiver recipients (i.e. adult residential providers and basic care, swing bed and nursing home facilities that provide respite care) and all extended personal care and nurse education providers will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:

- A) Result in imminent danger to the health, safety or security of the waiver recipient;
- B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
- C) Result in the hospitalization of the recipient;
- D) Result in a sentinel event i.e. death of a waiver recipient

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.

North Dakota Department of Health is responsible for oversight of medication administration in Basic Care Facilities N.D.A.C. 33-03-24.1-10. & Nursing Facilities protocol is provided in G-3-b-ii.

If a hospital is accredited, the accrediting organization (such as JCAHO) has responsibility for monitoring the hospital for certification purposes. If the hospital is not accredited, the Division of Health Facilities has certification responsibility. Each hospital is licensed annually by the Department of Health, Division of Health Facilities. Hospital licensing rules require compliance with the pharmacy requirements. Protocol provided in

G-3-b-ii.

Medication errors or omissions that occur during the provision of waived services must be reported to the State Medicaid agency per the policy described in G-3-c-i. The State Medicaid agency will review medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

In addition, Medication administration for extended personal care services is taught to the extended personal care service provider by a licensed nurse and this activity is governed under N.D.A.C. 55-05-04 of the Nurse Practice Act. The nurse gives instructions for medication administration based on the needs of a specific client and at a minimum, re-evaluates the client's needs every six months to determine if additional training is required or, whenever the client or legally responsible person notifies the nurse that a new medication has been ordered by a physician.

For all other waiver services N.D.A.C. 75-03-23-07 and the Qualified Service Provider handbook outline the standard for self-administration of medication. A definition of self-administration is located on back of the SFN 1699 Authorization to Provide Service form that is given to a provider prior to the implementation of service provision. The definition on the back of the form reads medication assistance is limited to assisting with client self-administration of routine oral medications by doing the following: opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container. If incidents are reported relating to self-administration of medication they are handled through the complaint process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of 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 % of waiver recipients/family/guardian that indicate during the annual quality review the people paid to help them with their services treat them with respect, have never injured them, taken or used their property, or used restrictive interventions including seclusion and/or restraint. N: Number of waiver recipients that indicate all items were met D: Total number of waiver recipients.

Data Source (Select one):

On-site observations, interviews, 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of reported complaints that were addressed by State Medicaid staff within the required 14 day timeframe. N: Number of reported complaints addressed within 14 days D: Total number of complaints.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Complaint database maintained by State

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

Performance Measure:

Number and percent of providers authorized to provide medication administration as part of a waived service that submitted an assurance to the State Medicaid agency that they will report medication errors or omissions per policy. N: Number of providers that submitted required assurance. D: Total number of providers required to submit this assurance.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Qualified Service Provider (QSP) records

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Upon initial enrollment and re-enrollment(every two years)	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and % of reported deaths of waiver recipients that did not indicate abuse or neglect. Total # of deaths reported. N: Number and % of reported deaths of waiver recipients that did not indicate abuse or neglect. D: Total # of deaths reported.

Data Source (Select one):

Critical events and incident reports

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 waiver recipients family/guardian that indicate during the annual quality review that the people paid to help them with their services have never used restrictive interventions including seclusion and/or restraint. N: Number of recipients who indicate they have never had restrictive interventions, including seclusion and/or restraint. D: Total number of waiver recipients.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify:
	<input type="text"/>

Performance Measure:

Number and percent of reported complaints regarding restraints that were substantiated through investigation, where follow-up is completed as required. N: Number of restraint complaints that are substantiated through investigation, where follow-up is completed as required. D: Total number of substantiated restraint 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of incidents where restrictive interventions were used and proper policies and procedures were followed. N = Number of incidents where restrictive interventions were used and proper policies and procedures were followed. D = Total number of incidents where restrictive interventions were used.

Data Source (Select one):

Critical events and incident reports

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. A “reported complaint” is any complaint or grievance that was reported to the Department of Human Service’s via phone, fax, email, in person contact or collateral contact. The Department accepts and reviews all complaints and must follow up on the complaint within 14 days of receiving it. Any State staff person can receive a complaint but there are two State staff designated to follow up on all complaints and make sure that the process is completed. These staff lead the process but a team approach is used to determine corrective actions etc. If the follow-up was not completed as required, the SMA would make a determination if the provider’s enrollment status will be affected.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including seclusion and/or restraint. Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. The use of all unauthorized restraints (those not written into the individual's plan, or those that do not follow the requirement of NDCC 50-10.2-02 (1) (k)), must be abated or eliminated immediately and meet the criteria of a Serious Event. These situations must be verbally reported to the HCBS Case Manager and Aging Services immediately. A incident report must also be submitted in writing to Aging Services within 24 hours of the incident. The Aging Services Team will review all incident reports to determine if restraints were used appropriately; it will be documented in the recipient's narrative. If it is determined restraints were not used appropriately and in accordance with state law, a formal referral to VAPS and/or ND Department of Health (licensing entity) will be initiated. VAPS and/or ND Department of Health will be responsible for independent review and follow up.

All providers who administer medications (i.e. adult residential providers, extended personal care and basic care, swing bed and nursing home facilities that provide respite care) will be required to submit an assurance that they will report medication errors or omissions to the State Medicaid agency that:

- A) Result in imminent danger to the health, safety or security of the waiver recipient;
- B) Have a potential for jeopardizing the waiver recipients health safety or security if left uncorrected;
- C) Result in the hospitalization of the recipient;
- D) Result in a sentinel event i.e. death of a waiver recipient

These conditions or practices must be abated or eliminated immediately. Providers must report the error within five days of the incident per policy. The HCBS Case Manager must report hospitalizations to the State Medicaid Agency.

In addition, all waiver recipients are also given a participants rights brochure that is explained to them by the Case Manager. The brochure includes information on how to report a complaint.

As soon a HCBS case manager learns of a waiver recipients death they must immediately report the death by providing the recipients' name, date of death, cause of death, location of death and any other pertinent information to the State Medicaid Agency. A Aging Services HCBS Program Administrator is then responsible to submit a Medical Services incident report. The incident report is sent to staff from the Department's Risk Management unit, Legal Advisory unit and the Director of Aging Services. The incident report will be reviewed upon receipt to determine if the circumstances surrounding the death are suspicions. If yes, the complaint protocol will be followed to determine the appropriate next steps which may include but are not limited to involving law enforcement. Quarterly this group will also meet to review all incident reports related to waiver recipient deaths to determine trends, need for education, additional services etc.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance. If an immediate threat to the recipient is identified case managers will be required to immediately report the issue to law enforcement and the State Medicaid agency. All other complaints must be reported per the complaint policy.

State Medicaid Agency staff are responsible for addressing all complaints. The State maintains a complaint database to track complaints by the date the complaint was received and responded to, and by type and resolution. Resolution of substantiated incidents could result in continued monitoring, termination of providers, removal of client from residences, referral to law enforcement etc.

The State Medicaid agency reviews medication error reports for compliance and corrective efforts. If issues are identified remediation techniques will include but are not limited to reporting the issue to the appropriate licensing agency, requesting additional information, developing corrective actions, and termination of provider status if necessary.

The State Medicaid Agency will review all reported waiver recipient deaths. If issues are identified remediation techniques may include referral to law enforcement, need for additional education, provider termination etc.

- ii. **Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: HCBS Case Managers	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

The incident report/ mortality review process will begin no later than 6/1/2017.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State Medicaid agency is responsible for evaluating the effectiveness and outcomes of the discovery, remediation, and quality improvement plans. The State prioritizes its remediation efforts to address any problems that involve client care or health and welfare issues first. The State keeps track of its quality improvement efforts by maintaining databases and statistics that include applicable time frames for completion. The State uses this information to make necessary changes to improve quality.

When pre-determined (QA) goals are not met or problems (that are not directly related to client care or health welfare and safety issues) are identified, the State discusses the issue(s) at team meetings and develops a plan of action. If the problem involves client care or health welfare and safety issues the problem is addressed immediately.

The action plan is documented in the team meeting minutes and may include, publishing the results of our quality improvement efforts in the HCBS Update that is provided to all Case Management entities, addressing unmet goals at the next Case Management training, rewriting updating policy/protocol as applicable.

Tools and/or instruments may also be revised to accommodate new measures. Annual letters are sent to all providers to provide them with information, make them aware of common errors and new requirements. If improper payment activities have occurred, adjustments to claims are processed, funds are recouped and providers may be placed on review or terminated if necessary.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Other

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Specify: <input type="text"/>	Specify: continuously & ongoing

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 HCBS team and discussed at HCBS team and administrative meetings. The State maintains a quality assurance plan that describes system improvements and other remediation efforts. The State keeps track of identified problems and tracks the number of errors that are identified over time. If no improvement is seen new strategies are put in place.

The home and community base services (HCBS) team includes staff members from Aging Services Division responsible for administering Federal and State funded HCBS and the Medical Services Division – HCBS Administration unit, Money Follows the Person Program Administrator, the State Unit on Aging Director, and the Medical Services Director or Assistant Medical Services Director.

The core HCBS team consists of the Aging Services Director who has overall responsibility for the team, four HCBS Program Administrators, one Program Specialist and one office assistant. One of the Human Service Program Administrators IV (HSPA IV) is the team lead and administers policies and programs for all services including the administration of the state funded services. This individual supervises the Human Service Program Administrators III (HSPA III) positions. These positions have general responsibility for any system changes made to the complaint resolution, the review process and some aspects of the quality assurance.

The other Human Service Program Administrator HSPA IV position is a Registered Nurse that is responsible for the Technology Dependent Waiver administration and Extended Personal Cares program administration. This position is responsible for system design changes that would involve waiver amendments and certain aspects of the quality assurance process.

In addition, there are three staff (two HCBS Program Administrators and one enrollment specialist) located in the Medical Services Administration Unit who have responsibility as it relates to the QSP enrollment process, system changes related to provider billing, rate setting and provider audits.

The HCBS Unit of the ND Medical Services Division has partnerships with other Units within the Medical Services Division. External resources are vital to the development of effective and efficient services. These entities participate as applicable: County Social Service Boards, service providers, family members, consumers, Long Term Care Association, advocates, and other interested parties.

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

The States quality improvement strategy is discussed during team meetings and administrative meetings that are scheduled quarterly. System changes and common errors or individual problems that have been identified via the audit process are also discussed. Once a year the State calculates statistics and reviews the results of the quality improvement plan. Trends are tracked and reviewed against the previous year's results to see where improvements have been made and where future quality improvement efforts need to be focused. The results of this analysis are discussed with the HCBS team and the adult services committee and distributed to Case Managers through the quarterly update. Issues regarding recipient health, safety, and welfare are addressed immediately.

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 Department of Human Services currently has approximately 1200 enrolled Qualified Service Providers (QSPs) including case management entities. Waiver providers are not required to secure an independent audit of their financial statements. Waiver providers are not required to secure an independent audit of their financial statements and not all providers are subject to a single State audit.

The State Medicaid agency completes onsite or desk reviews of all 48 enrolled case management providers on an annual basis to determine if operational and administrative functions have been carried out according to policy and procedures. Case Management audits alternate each year between desk audits and onsite audits. In addition, the State Medicaid agency completes desk reviews of statistically valid number of HCBS waiver recipients paid claims data to determine if activities and tasks were billed/paid within allowable limits. The paid claims data review is conducted annually. Sample size for the waiver paid claims review are based on a 95% confidence level and a confidence interval of 5 based on the number of paid claims during the timeframe of the data pull. The link used to establish the sample size is: <http://www.raosoft.com/samplesize.html>

The State Medicaid agency also completes a minimum of 5% or 85 QSP reviews annually. The 85 entities may provide services under all HCBS programs in ND including the two State funded programs, the HCBS and Technology Dependent waiver and Medicaid State Plan - Personal Care. The process to choose who will be reviewed from this group is not random. The providers are chosen because irregularities in their billing patterns or other concerns have been identified. The State Medicaid agencies provider review process consists of one year of claim history and the evaluation of a minimum of one month of county case management records/activities, and provider records. Within these reviews, various components are evaluated to determine if activities and tasks were billed/paid within allowable limits. Provider records and logs are evaluated to determine if proper procedure codes were utilized, and services were delivered in accordance with the authorization of services.

In addition, the State Medicaid Agency performs audits of certain services that have been identified through discussion with HCBS and SURS team members to have a higher potential for inappropriate billing or other irregularities that would warrant a review of all claims data related to that service. Annually or as needed, the Medical Services Division HCBS unit and staff from the Aging Services Division determine audit topics relative to the services provided by the Aging Services Division. The Fraud, Waste, and Abuse (FWA) Administrator serves as an advisor on the auditing activities to ensure consistency and integrity throughout the process. Factors that lead to a decision to audit a particular service include looking at services with high utilization, frequent errors, and or patterns of irregular billing. A minimum of one targeted service audit is conducted annually.

Different waiver services are generally audited each year but a service that has already been audited may include another audit within that year to assure compliance or technical assistance efforts were achieved. Sample size for service audits is based on a 95% confidence level and a confidence interval of 5 based on the number of clients utilizing the service during the timeframe of the data pull. There may be instances where the sample size is such that every provider in the state would not necessarily be selected randomly for an audit. In those instances, five claims for each provider are randomly selected to ensure that each provider has at least one claim included in the audit. Then, the amount of claims needed to meet the sample size is randomly selected from the remaining claims in the data report. The link used to establish the sample size is: <http://www.raosoft.com/samplesize.html>

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 audited again in the near future to assure compliance.

On 2/1/2017 the following HCBS Medicaid waiver services will be prior authorized in the MMIS system and will require a Service Authorization (SA) to be entered for all clients. Adult Day Care, Homemaker, Respite Care, Supported Employment, Adult Foster Care, Chore, Environmental Modification, Extended Personal Care, Home Delivered Meals, Non-Medical Transportation, Specialized Equipment and Supplies, Supervision, Transitional Living, Emergency Response System, and Community Transition Services. If there is not a valid SA in the system, claims will be denied. In addition, if a provider tries to bill over the authorized amount or for a service that is not authorized the claims will be denied. Family Personal Care and Adult Residential Care services do not require an SA because their utilization is controlled through other edits contained in MMIS and through parameters built into the HCBS waiver benefit plan coverage. Adult residential services must be prior approved by an HCBS Program Administrator and the system contains edits that control the rate

paid. The number of units is also limited in the system to the calendar month.

The State agency responsible for conducting the state’s financial audit is the Office of the State Auditor. An audit of the State of North Dakota Comprehensive Annual Financial Report is conducted annually by the State Auditor’s Office. This audit involves examining, on a test basis, evidence supporting the revenues, expenditures and disclosures in the financial statements, assessing the accounting principles used and evaluating the overall financial statement presentation.

An agency audit of the Department of Human Services is performed every two years. This audit is a result of the statutory responsibility of the State Auditor to audit each state agency once every two years and is a report on internal control, on compliance with State and Federal laws, and on efficiency and effectiveness of agency operations.

The State Auditor’s Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability 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 claims that are paid in accordance with the approved waiver.
N: Number of claims paid in accordance with 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	

		<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of case managers who report during the face to face quality review that the client's appearance and appearance of their environment support that the provider is providing the amount of services as indicated on the plan of care. N: Number and % who report services were actually provided. D: Total number of quality reviews.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data	Sampling Approach (check each that applies):
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collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: HCBS Case Manager	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 provider payment rates that are consistent with rate methodology approved in the approved waiver application or subsequent amendment. N: Number of provider payment rates consistent with waiver methodology. D: Total number of payments.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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. Statistical significance for the review of paid claims data will be determined by calculating a representative random sample of waiver recipient's paid claims data using credible parameters including a 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution. The random representative sample will be calculated from the total number of paid waiver claims for the previous waiver year (for example in waiver year 3 the review will include claims paid in waiver year 2) The state will use a research number randomizer to choose which waiver claims to review.

The HCBS Case Manager will be required to use one of their required quarterly home visits to conduct a quality review with the recipient. Using a quality questionnaire developed by the State Medicaid agency the case managers will conduct recipient interviews and use observation of the environment to determine if: a) The provider is providing the services in the type, scope, amount, duration, and frequency as required by the care plan; b) The provider is arriving and leaving the recipient's home as scheduled; c) The environment and recipient's appearance support that the service is provided in the amount required in the care plan; d) The services and the amount of services meet the recipient's needs; e) The services available assure that health, welfare, and safety needs are met; f) The provider does not use or take the recipient's property; g) The provider treats the recipient with respect; h) The provider has never injured the recipient; i) The provider has never used restrictive interventions including seclusion and/or restraint. Case Managers are required to submit the results of the quality review to the State Medicaid agency who will monitor them for compliance.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The State is responsible for addressing individual problems. Resolution methods include but are not limited to providing education / technical assistance, rewriting billing instructions/ provider information to increase understanding, sending written corrective action plans to providers, recouping funds, placing providers on review, and terminating provider status if necessary.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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).

Rates are reviewed biannually when the Department's 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), the number of providers enrolled to provide care, and public comments. The SMA sets rates for services after the Legislature (LEG) appropriates funds for those services. Rates may be increased by LEG action. The LEG may or may not grant an inflationary increase during the Legislative session which is held every two years. Testimony is encouraged during LEG Budget Hearings and Interim Human Serv. Cmt hearings, qualified service providers (QSPs) give testimony regarding QSP rates.

The SMA gathers input on HCBS including rates via a survey process or through public hearings that are held in every region of the State, including reservation communities. The public input is compiled and considered when determining budget and service delivery priorities. Waiver recipients are made aware of the provider's rate when they choose their QSP. The rate for each service is also listed on the clients person centered plan. When LEG rate increases are approved, clients who have a recipient liability are informed in writing that the service costs will increase.

The SMA maintains a QSP list <https://secure.apps.nd.gov/dhs/qsp/qspsearch.aspx> that includes the rates by provider. This list is available to clients and the public via an online searchable database. Some rates are unique i.e. Adult Foster Care and Family Personal Care to the individual client because they are based on the client assessed needs. Due to confidentiality these rates are not available to the public but are provided to the client and listed on their individual care plan.

Rates for Medicaid waiver services are adequate to recruit and retain QSPs across the State to sufficiently meet client needs. This is evident in the fact that we have over 1200 enrolled QSPs statewide and we do not have a waiting list for waived services.

We are continuing to evaluate how the Fair Labor Standards Act (FLSA) final rule applies to qualified service providers (QSP) and whether changes to our program will be necessary if they are subject to the requirements of the FLSA.

- The individual and agency fee for service rates for respite care, chore, and supported employment were initially set during the 2007 LEG Session. A maximum rate was calculated using the SFY 06 individual and agency rates. Individual providers requested their rate up to a maximum rate allowed. Agency rates were based on actual cost reports and were inflated forward to reflect LEG rate increases. The rates have since been reviewed and increased based on LEG action.

- On 9/1/2016 the homemaker 15-minute unit fee for service agency and individual provider rate was revised and was based on 90% of the current fee schedule. Originally individual providers requested their rate up to a maximum rate allowed and the agency fee for service rate was based on actual costs and includes allowable administrative costs to the agency. Allowable administrative costs include the indirect cost of providing services such as salaries, fringes, recruiting, telephone, billing, office space, utilities, janitorial, bonding, and liability insurance.

- On 9/1/2016 the rural differential homemaker rates was also updated. The rural differential rate methodology remains the same as described below, but the homemaker rural differential rate is based on the updated homemaker fee for service rate.

- The individual and agency provider fee for service rates for Extended Personal Care was initially established in 2007 based on the cost of providing similar services i.e. respite care and personal care. The original maximum rate was calculated using the SFY 06 individual and agency rates. Individual providers requested their rate up to a maximum rate allowed. Agency rates were based on actual cost reports and were inflated forward to reflect LEG rate increases. The rates have since been reviewed and increased based on LEG action.

- The original individual nurse ed. rate was based on the rates paid for a similar service i.e. nurse management. That rate was set in 2007 after considering Job Service data about the average wage paid in ND for RN's and LPN's inflated to cover admin and other costs. The LEG provided both agency and ind. nurse ed providers a .25 per 15 minute unit plus 3% increase on 7/1/13 & 7/1/2014.

- The agency fee for service rate for nurse ed. is based on actual costs and includes allowable administrative costs to the agency. Allowable administrative costs include the indirect cost of providing services such as salaries, fringes, recruiting, telephone, billing, office space, utilities, janitorial, bonding, and liability insurance.

- Rural Differential (RD) Rate: On 1-1-14 the LEG appropriated funds to allow the following services to be paid at a higher rate when they are provided to recipients who live in rural areas: respite care, homemaker, personal care, Ex-PC (includes nurse ed), chore and transitional living services. Providers who are willing to travel at least 21 miles round trip to provide care to waiver recipients in rural areas may be paid at a higher rate. (Providers who are not traveling to rural areas to provide these services will continue to use the previous rate.) The SMA has established three rate tiers based on the number of miles a provider travels round trip to provide care. Tier1 covers (21-50 miles), Tier2 (51-70 miles) and Tier3 (71+ miles). Estimates for the higher rates were based on the mid-point mileage amount of each tier, multiplied by 27.75 cents per mile (1/2 of the GSA mileage Rate as of 4-2012).

- On 1/1/14 transitional living rates were calculated using the same agency 15 minute unit rate that was used to pay for similar services i.e. respite care, chore, and personal care services.

- Supervision rates were set based on LEG action and were calculated based on 2013 average entry level wage paid for similar work i.e. child care in ND.

All other services are calculated in the following manner and were set during the 2013 LEG session:

- HDM - The per meal rate was originally based in 2007 on the current average cost of providing OAA nutrition services. The rates have since been reviewed and increased based on LEG action.

- Agency providers that want to provide adult day care, adult residential care, or emergency response services are required to forward agency cost reports at the time of enrollment. Direct, indirect, and admin costs are provided to the State for rate determination. The agency cost reports are reviewed for reasonableness and a provider rate is set. Currently admin costs in excess of 15% of the direct care costs for providing these services are excluded when calculating the rate. Adult day care and residential care providers received an \$8.00 per day plus 3% rate increase on 7-1-2013.

- Adult foster care (AFC), and family personal care, provider rates are determined based on a formula and factor based system. This system considers the tasks required to care for specific clients. Each allowable task has an identified point factor. The total points are multiplied by a factor, which is unique to the specific service. The factor formula then calculates a daily rate. The assigned daily rate takes into consideration the limit for AFC and family personal care. If the rate is at the limit or less, the provider is notified of the assigned rate. If the rate is greater than the limit, the rate is

reduced and the provider is notified of the rate. The LEG provided an \$8.00 per day plus 3% increase to the previous limits for these services in 2013.

- Rates for self-employed indep. contractors who enroll to provide CM services under the waiver were calculated in 2012 by using the US Bureau of Labor and Statistics average wage paid for social workers in ND plus the average cost of benefits. That rate was then multiplied by the average amount of time it takes to complete an annual assessment and the average time it takes to complete a quarterly contact.

- Agency CM providers - CM rates were initially established by a committee that was charged with establishing the rates based on the average salary being paid to social workers at that time and other information provided by the CM entities. Rates were reviewed in the 1990s and increased based on the cost of providing services at the time. Rates have since been inflated based on LEG action. The Agency rate is used for all waiver services and was inflated to account for the estimated average additional time it takes to participate in PCP meetings with a team and/or conduct additional home visits. Annual review of CM records indicates that waiver cases are more complex and/or require frequent changes to the PCP. The unit rate is a monthly rate. The estimated number of units is 4 units per consumer, per year. If CM client contact that impacts eligibility, care planning etc. or, they complete an assessment with the client on a given day during the month they would be paid 1 unit of CM at the monthly rate. The max amount they could receive would be the monthly rate regardless of how many billable tasks they performed that month. Consumers are made award of the CM costs on their ICP. Each CM agency receives the same rate for providing services. The rates have since been reviewed and increased based on LEG action.

- Environmental modification (Env Mod) and specialized equipment (Sp Eq) costs are based on the actual cost of the modification or the cost of the equipment. Cost proposals for env mod and Sp Eq are reviewed to assure that preliminary costs do not exceed the individual budget amount.

- Nonmedical transportation rates include a flat round trip rate for in-town trips and a per mileage rate for out of town trips. The current mileage rate is based on the state mileage rate.

- The rate for transition coordination under community transition services is calculated by using the median hourly wage paid to a social worker in North Dakota for similar work based on the Bureau of Labor (\$28.00) and multiplying it by 30% for fringes and by 15% for administrative costs.

- The amount for one-time transition costs under community transition services is based on the historical cap of similar services provided under the Money Follows the Person (MFP) grant inflated by 3% for WY 3-5.

A 3% inflationary increase to all provider rates was applied for 9 months of each waiver year based on historical rate increases granted to waiver providers. Inflation was added for 9 months each year because rate adjustments are historical made in July of each year. This amount is consistent with the current CPI for Medical Care Services which is 3.6% ending Jan 2017.

Providers are notified that they must charge private pay clients at a rate equal to, or greater than, the rate set with the State. In all cases, the provider is notified of the initial rate and is notified when the rate changes.

- 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:

All providers are required to complete requests for payments on a SFN 1730 HCBS billing form or use the web portal available in MMIS. Paper claims and those submitted via the web portal go directly from the provider to MMIS.

All service plans are reviewed and approved by Aging Services staff. 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 provide to the participant. In addition as of 2/1/2017, the information from the approved plan is used to create a service authorization (SA) in MMIS for all waiver services with the exception of adult residential care and family personal care. The SA includes 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. No SA is created for adult residential care and family personal care because MMIS contains other edits that prevent billing errors for these services.

Case Managers have frequent contact with waiver recipients and are required to make a minimum of four quarterly face to face visits each year. The visits include an assessment to determine if their service needs are being met. One of the

quarterly visits is a quality review where the recipient is asked questions about the frequency and quality of their care to assure services are being rendered in the type, scope, amount, and frequency listed on the care plan. In addition, staff from Medical Services conduct provider reviews which include a review of billing records and provider documentation to assure services were rendered per the authorization to provide services.

If billing errors are found providers are notified of the issue in writing and adjustments are filed which create an accounts receivable in MMIS to recoup the funds. If a provider is closed or is not actively billing they are asked to remit the payment ASAP. If they do not respond within the timeframe requested the matter is turned over to a collection agency.

All adjustments and corrections are reported on the CMS 64 report which reduces the State's federal reimbursement.

Participant's or their legal representatives make an independent choice of provider. The case manager may assist a recipient in making an independent choice of provider by showing them a list of available providers and or helping them identify a friend, neighbor etc. who may be interested in enrolling to provide the care. Participant's or their legal representatives are required to indicate that they have made an independent choice on the plan of care.

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 deny claims if the individual is not an approved Medicaid recipient. The State receives reports from Dual Diagnosis Management Ascend Management Innovations, LLC. identifying individuals

screened eligible for the waiver and the information including the eligibility period of the screening is entered into the MMIS.

To assure proper claims payment, the Department conducts post payment audits to evaluate payments for accuracy, accountability and reasonableness. As part of the State's quality assurance efforts desk reviews of statistically valid number of HCBS waiver recipient's paid claims data is reviewed to determine if activities and tasks were billed/paid within allowable limits.

Statistical significance of paid claims data will be determined by calculating a random representative sample of the total number of paid waiver claims for the previous waiver year (for example in waiver year 3 the State will use data from waiver year 2). The following parameters will be used 95% confidence level, with a 5% margin of error/confidence interval and a 50% distribution. The reviews are completed annually.

In addition to the representative sample of paid claims that will be calculated using the methodology described above, the State will also conduct annual on and off site reviews of a smaller sample (no less than 85) of provider files to determine if services are being provided according to policy and procedures and to determine if services are delivered by the type, scope, amount, duration and frequency specified in the service plan. These cases are not chosen randomly but are based on purposeful targeting of cases where billing irregularities have been found or when a case is especially complex. This includes an evaluation of the comprehensive assessment and the results are compared to the authorization to provide services and the client's service plan. The payment histories are cross-referenced with provider records. Inadequate records and inaccurate requests for payments are reported to the providers and findings and corrective actions are required.

In addition, the State Medicaid Agency performs audits of certain services that have been identified through discussion with HCBS and SURS team members to have a higher potential for inappropriate billing or other irregularities that would warrant a review of all claims data related to that service. A minimum of one targeted service audit is conducted annually.

If any of these reviews reveal payments that are in excess of what is authorized or are unallowable they are recouped by the State. Recoupments are made through a provider adjustment or direct provider payment.

All service plans are reviewed and approved by Aging Services staff. 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 provide to the participant. In addition as of 2/1/2017, the information from the approved plan is used to create a service authorization (SA) in MMIS for all waiver services with the exception of adult residential care and family personal care. The SA includes 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. No SA is created for adult residential care and family personal care because MMIS contains other edits that prevent billing errors for these services.

Case Managers have frequent contact with waiver recipients and are required to make a minimum of four quarterly face to face visits each year. The visits include an assessment to determine if their service needs are being met. One of the quarterly visits is a quality review where the recipient is asked questions about the frequency and quality of their care to assure services are being rendered in the type, scope, amount, and frequency listed on the care plan. In addition, staff from Medical Services conduct provider reviews which include a review of billing records and provider documentation to assure services were rendered per the authorization to provide services.

If billing errors are found providers are notified of the issue in writing and adjustments are filed which create and accounts receivable in MMIS to recoup the funds. If a provider is closed or is not actively billing they are asked to remit the payment ASAP. If they do not respond within the timeframe requested the matter is turned over to a collection agency.

All adjustments and corrections are reported on the CMS 64 report which reduces the State's federal reimbursement.

Participant's or their legal representatives make an independent choice of provider. The case manager may assist a recipient in making an independent choice of provider by showing them a list of available providers and or helping them identify a friend, neighbor etc. who may be interested in enrolling to provide the care. Participant's or their legal representatives are required to indicate that they have made an independent choice on the plan of care.

- 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:

County Social Service Boards may provide Case Management, Respite Care, Homemaker Service, Non-Medical Transportation, Chore Service, Supervision, and Extended Personal Care. North Dakota Indian Tribal entities may also enroll to provide services for which they are qualified to provide and choose to provide.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- 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:

Provider agency cost reports separately identify the costs of room and board. The room and board expenses are not included when determining the provider rate. Providers of service are responsible for collecting room and board directly from the client.

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	19595.58	23149.00	42744.58	89144.00	104825.00	193969.00	151224.42
2	21090.54	24098.00	45188.54	93601.00	109123.00	202724.00	157535.46
3	22179.83	25086.00	47265.83	98281.00	135597.00	233878.00	186612.17
4	23035.03	26115.00	49150.03	103195.00	141156.00	244351.00	195200.97
5	23960.20	27186.00	51146.20	108355.00	146943.00	255298.00	204151.80

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	496		496
Year 2	516		516
Year 3	537		537
Year 4	558		558
Year 5	580		580

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.

The average length of stay was calculated by using an average of the length of stay data reported on the last three (2013-2015) CMS 372 reports. This report shows the total number of days of waiver coverage for the home and community based services waiver. The report also shows the unduplicated count of recipients during that period of time. The average length of stay calculated from the reports is 279 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 for these estimates is as follows:

Estimated Number of Users:

With the exception of supervision, independent case management, environmental modification, and community transition services, the estimated number of users for WY1 is based on the highest utilization rate for each service over the past 3 waiver years inflated by 4% in WY2-WY5. These numbers were obtained from the CMS 372 reports. The estimated number of users for supervision is based on current utilization because of a lack of historical data. The service did not start until December 2014. The estimated number of waiver recipients who will choose an independent case manager is estimated at 5% of the WY1 slots. Due to a lack of historical data environmental modification was calculated based on the average current cost being paid for this service.

Community transition services was calculated based on historical data of the number of transitions from nursing facilities under the Money Follows the Person (MFP) grant.

Average Units Per User:

With the exception of environmental modification and community transition services, the average units per user were calculated using data from the latest WY3 (04/01/2014-03/31/2015) CMS 372 report. Total expenditures for each service were divided by the current average unit rate and current number of users. Environmental modification was not utilized in WY3 (04/01/2014-03/31/2015) therefore the current numbers of units per user were used. Community transition services was calculated based on historical data of the number of units for transitions from nursing facilities under the Money Follows the Person (MFP) grant. For all services, the estimated numbers of users were increased by 1% for WY2-WY5. State utilization data shows a slight increase in the number of uses who used waiver services so modest growth was included in the waiver.

For the services that also have an RD rate the State Medicaid Agency estimates that 23% of waiver recipients using these services would qualify for the rural differential rate. 15% would fall into Tier 1(21-50 miles), 4% in Tier 2 (51-70 miles), 4% in Tier 3 (71+ miles). For all RD eligible services, the estimated numbers of users were increased by 1% for WY2-WY5.

Average Cost Per Unit:

The average cost per unit was calculated by using the current average rate paid for each service inflated by 3% for 9 months in WY1 and continued in the first 3 months for WY2-WY5. Inflation was added for 9 months the first year because rate adjustments are historical made in July of each year. 3% is based on historical annual rate increases granted to waiver providers.

Homemaker, respite care, chore, and extended personal care/nurse education non rural differential rates are a blended average of the agency and individual current fee for service rates paid for each service. The average RD rates for these services were calculated in the same way but an average of the agency and individual current fee for service RD rates paid for each service was used.

Transitional Living service can only be provided by an agency and therefore the cost per unit is based on the current agency rate. The average RD rate for this service was calculated in the same way but an average of the agency RD rate was used.

Adult day care, adult residential services, adult foster care, emergency response, environmental modification, family personal care and specialized equipment and supplies were calculated using an average of all of the rates paid for each service. The list of rates is maintained by the State Medicaid Agency. This method was used because the rates for these services are unique to each provider or client.

Agency case management costs per unit were determined by calculating an average of the current annual agency assessment rate and the current agency case management rate paid for all other agency case management contacts. Independent case management costs per unit were determined by calculating an average of the current annual independent case management assessment rate and the current rate paid for all other independent case management contacts.

Non-medical transportation costs per unit were calculated by computing an average unit rate based on current actual costs of in town flat rate trips and out of town per mile trips.

Community transition services was calculated based on historical data of the number of units multiplied by the rate of the transitions from nursing facilities under the Money Follows the Person (MFP) grant.

- 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:

The 372 report for 04/01/2015/03/31/2015 for the HCBS waiver indicates that the estimated cost of all other services paid on behalf of waiver recipients averaged \$22237. This does not include cost of prescribed drugs that are furnished to Medicare/ Medicaid eligible individuals under Part D. For WY1-WY5 this figure was inflated by 4.1% based on the current medical Consumer Price Index (CPI).

D' is based on the most recently 372 report for this waiver and G' was based on the Department's fiscal spend-down report so both sources use actual expenditure data. Nursing home recipients may use more "other" Medicaid services because their conditions may be less stable or, because they are receiving services in a medical model where referral for additional healthcare services might be more common.

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

A state generated financial report 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). This amount was inflated by 5% for WY 1 -5 based on historical average cost increases for nursing facility services.

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:

The Medical Assistance spend-down report for July 2016 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. This amount was inflated by 4.1% for WY1-WY5 based on the current medical Consumer Price Index (CPI).

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	
Adult Day Care	
Adult Residential Care	
Case Management	
Homemaker	
Respite Care	
Supported Employment	
Adult Foster Care	
Chore	
Community Transition Services	
Emergency Response	
Environmental Modification	
Extended Personal Care	
Family Personal Care	
Home Delivered Meals	
Non-Medical Transportation	
Specialized Equipment & Supplies	
Supervision	
Transitional Living	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						12441.04
Adult Day Care	1/2 day	2	164.00	37.93	12441.04	
Adult Residential Care Total:						5869681.20
Adult Residential Care	Daily	135	348.00	124.94	5869681.20	
Case Management Total:						284101.04
Independent Case Management	Monthly	25	4.00	129.90	12990.00	
Agency Case Management	Monthly	376	4.00	180.26	271111.04	
Homemaker Total:						136939.81
Rural Differential Tier 1	15 min.	9	371.00	7.67	25610.13	
Rural Differential Tier 2	15 min.	2	371.00	9.13	6774.46	
Rural Differential Tier 3	15 min.	2	371.00	10.25	7605.50	
Homemaker	15 min.	47	371.00	5.56	96949.72	
Respite Care Total:						362820.48
Rural Differential Tier 1	15 min.	9	838.00	8.28	62447.76	
Rural Differential Tier 2	15 min.	3	838.00	9.74	24486.36	
Rural Differential Tier 3	15 min.	3	838.00	10.86	27302.04	
Respite Care	15 min.	48	838.00	6.18	248584.32	
Supported Employment Total:						13442.00
Supported Employment	15 min.	4	470.00	7.15	13442.00	
Adult Foster Care Total:						236019.84
Adult Foster Care	Daily	12	272.00	72.31	236019.84	
Chore Total:						1063.30
Chore Rural Differential Tier 1	15 min.	1	35.00	8.28	289.80	
Chore Rural Differential Tier 2	15 min.	1	35.00	9.74	340.90	
Chore Rural Differential Tier 3	15 min.	0	35.00	10.86	0.00	
GRAND TOTAL:					9719407.79	
Total Estimated Unduplicated Participants:					496	
Factor D (Divide total by number of participants):					19595.58	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore	15 min.	2	35.00	6.18	432.60	
Community Transition Services Total:						0.00
One-Time Transition Cost	Per Item	0	1.00	3000.00	0.00	
Transition Coordination	15 min.	0	960.00	10.50	0.00	
Emergency Response Total:						30867.20
Emergency Response	Monthly	91	8.00	42.40	30867.20	
Environmental Modification Total:						18773.48
Environmental Modification	Per Job	4	1.00	4693.37	18773.48	
Extended Personal Care Total:						148910.30
Nurse Education Rural Differential Tier 1	15 min.	3	56.00	16.37	2750.16	
Nurse Education Rural Differential Tier 2	15 min.	2	56.00	17.83	1996.96	
Nurse Education Rural Differential Tier 3	15 min.	1	56.00	18.94	1060.64	
Nurse Education	15 min.	14	56.00	14.26	11179.84	
Extended Personal Care Rural Differential Tier 1	15 min.	3	931.00	8.28	23126.04	
Extended Personal Care Rural Differential Tier 2	15 min.	2	931.00	9.74	18135.88	
Extended Personal Care Rural Differential Tier 3	15 min.	1	931.00	10.86	10110.66	
Extended Personal Care	15 min.	14	931.00	6.18	80550.12	
Family Personal Care Total:						1550908.92
Family Personal Care	Daily	93	302.00	55.22	1550908.92	
Home Delivered Meals Total:						34359.00
Home Delivered Meals	Per Meal	20	195.00	8.81	34359.00	
Non-Medical Transportation Total:						12204.08
Non-Medical Transportation	Trip	19	37.00	17.36	12204.08	
Specialized Equipment & Supplies Total:						16112.90
Specialized Equipment & Supplies	Per Item				16112.90	
GRAND TOTAL:					9719407.79	
Total Estimated Unduplicated Participants:					496	
Factor D (Divide total by number of participants):					19595.58	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		5	1.00	3222.58		
Supervision Total:						631168.20
Supervision	15 min.	15	17316.00	2.43	631168.20	
Transitional Living Total:						359595.00
Transitional Living Rural Differential Tier 1	15 min.	2	3660.00	9.25	67710.00	
Transitional Living Rural Differential Tier 2	15 min.	1	3660.00	10.72	39235.20	
Transitional Living Rural Differential Tier 3	15 min.	1	3660.00	11.83	43297.80	
Transitional Living	15 min.	8	3660.00	7.15	209352.00	
GRAND TOTAL:						9719407.79
Total Estimated Unduplicated Participants:						496
Factor D (Divide total by number of participants):						19595.58
Average Length of Stay on the Waiver:						279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						12971.24
Adult Day Care	1/2 day	2	166.00	39.07	12971.24	
Adult Residential Care Total:						6323826.60
Adult Residential Care	Daily	140	351.00	128.69	6323826.60	
Case Management Total:						304287.44
Independent Case Management	Monthly	26	4.00	133.80	13915.20	
Agency Case Management	Monthly	391	4.00	185.66	290372.24	
Homemaker Total:						146913.75
Rural Differential Tier 1					26662.50	
GRAND TOTAL:						10882717.46
Total Estimated Unduplicated Participants:						516
Factor D (Divide total by number of participants):						21090.54
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min.	9	375.00	7.90		
Rural Differential Tier 2	15 min.	2	375.00	9.40	7050.00	
Rural Differential Tier 3	15 min.	2	375.00	10.55	7912.50	
Homemaker	15 min.	49	375.00	5.73	105288.75	
Respite Care Total:						387831.78
Rural Differential Tier 1	15 min.	9	846.00	8.53	64947.42	
Rural Differential Tier 2	15 min.	3	846.00	10.04	25481.52	
Rural Differential Tier 3	15 min.	3	846.00	11.18	28374.84	
Respite Care	15 min.	50	846.00	6.36	269028.00	
Supported Employment Total:						13984.00
Supported Employment	15 min.	4	475.00	7.36	13984.00	
Adult Foster Care Total:						246677.76
Adult Foster Care	Daily	12	276.00	74.48	246677.76	
Chore Total:						1095.15
Chore Rural Differential Tier 1	15 min.	1	35.00	8.53	298.55	
Chore Rural Differential Tier 2	15 min.	1	35.00	10.04	351.40	
Chore Rural Differential Tier 3	15 min.	0	35.00	11.18	0.00	
Chore	15 min.	2	35.00	6.36	445.20	
Community Transition Services Total:						404559.00
One-Time Transition Cost	Per Item	30	1.00	3067.50	92025.00	
Transition Coordination	15 min.	30	970.00	10.74	312534.00	
Emergency Response Total:						33196.80
Emergency Response	Monthly	95	8.00	43.68	33196.80	
Environmental Modification Total:						19336.68
Environmental Modification	Per Job	4	1.00	4834.17	19336.68	
GRAND TOTAL:					10882717.46	
Total Estimated Unduplicated Participants:					516	
Factor D (Divide total by number of participants):					21090.54	
Average Length of Stay on the Waiver:					279	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Personal Care Total:						161763.12
Nurse Education Rural Differential Tier 1	15 min.	3	57.00	16.86	2883.06	
Nurse Education Rural Differential Tier 2	15 min.	2	57.00	18.36	2093.04	
Nurse Education Rural Differential Tier 3	15 min.	1	57.00	19.51	1112.07	
Nurse Education	15 min.	15	57.00	14.69	12559.95	
Extended Personal Care Rural Differential Tier 1	15 min.	3	940.00	8.53	24054.60	
Extended Personal Care Rural Differential Tier 2	15 min.	2	940.00	10.04	18875.20	
Extended Personal Care Rural Differential Tier 3	15 min.	1	940.00	11.18	10509.20	
Extended Personal Care	15 min.	15	940.00	6.36	89676.00	
Family Personal Care Total:						1682498.95
Family Personal Care	Daily	97	305.00	56.87	1682498.95	
Home Delivered Meals Total:						37563.96
Home Delivered Meals	Per Meal	21	197.00	9.08	37563.96	
Non-Medical Transportation Total:						13231.20
Non-Medical Transportation	Trip	20	37.00	17.88	13231.20	
Specialized Equipment & Supplies Total:						16596.30
Specialized Equipment & Supplies	Per Item	5	1.00	3319.26	16596.30	
Supervision Total:						702358.24
Supervision	15 min.	16	17489.00	2.51	702358.24	
Transitional Living Total:						374025.49
Transitional Living Rural Differential Tier 1	15 min.	2	3697.00	9.53	70464.82	
Transitional Living Rural Differential Tier 2	15 min.	1	3697.00	11.04	40814.88	
Transitional Living Rural Differential Tier 3	15 min.	1	3697.00	12.19	45066.43	
Transitional Living	15 min.	8	3697.00	7.36	217679.36	
GRAND TOTAL:						10882717.46
Total Estimated Unduplicated Participants:						516
Factor D (Divide total by number of participants):						21090.54
Average Length of Stay on the Waiver:						279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						13440.16
Adult Day Care	1/2 day	2	167.00	40.24	13440.16	
Adult Residential Care Total:						6870066.50
Adult Residential Care	Daily	146	355.00	132.55	6870066.50	
Case Management Total:						326205.92
Independent Case Management	Monthly	27	4.00	137.81	14883.48	
Agency Case Management	Monthly	407	4.00	191.23	311322.44	
Homemaker Total:						160052.76
Rural Differential Tier 1	15 min.	10	378.00	8.14	30769.20	
Rural Differential Tier 2	15 min.	2	378.00	9.69	7325.64	
Rural Differential Tier 3	15 min.	2	378.00	10.87	8217.72	
Homemaker	15 min.	51	378.00	5.90	113740.20	
Respite Care Total:						422438.40
Rural Differential Tier 1	15 min.	10	855.00	8.79	75154.50	
Rural Differential Tier 2	15 min.	3	855.00	10.34	26522.10	
Rural Differential Tier 3	15 min.	3	855.00	11.52	29548.80	
Respite Care	15 min.	52	855.00	6.55	291213.00	
Supported Employment Total:						14523.28
Supported Employment	15 min.	4	479.00	7.58	14523.28	
GRAND TOTAL:					11910570.08	
Total Estimated Unduplicated Participants:					537	
Factor D (Divide total by number of participants):					22179.83	
Average Length of Stay on the Waiver:					279	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Foster Care Total:						278227.17
Adult Foster Care	Daily	13	279.00	76.71	278227.17	
Chore Total:						1160.28
Chore Rural Differential Tier 1	15 min.	1	36.00	8.79	316.44	
Chore Rural Differential Tier 2	15 min.	1	36.00	10.34	372.24	
Chore Rural Differential Tier 3	15 min.	0	36.00	11.52	0.00	
Chore	15 min.	2	36.00	6.55	471.60	
Community Transition Services Total:						559490.80
One-Time Transition Cost	Per Item	40	1.00	3159.53	126381.20	
Transition Coordination	15 min.	40	979.00	11.06	433109.60	
Emergency Response Total:						35272.16
Emergency Response	Monthly	98	8.00	44.99	35272.16	
Environmental Modification Total:						19916.76
Environmental Modification	Per Job	4	1.00	4979.19	19916.76	
Extended Personal Care Total:						168185.15
Nurse Education Rural Differential Tier 1	15 min.	3	57.00	17.36	2968.56	
Nurse Education Rural Differential Tier 2	15 min.	2	57.00	18.91	2155.74	
Nurse Education Rural Differential Tier 3	15 min.	1	57.00	20.10	1145.70	
Nurse Education	15 min.	15	57.00	15.13	12936.15	
Extended Personal Care Rural Differential Tier 1	15 min.	3	950.00	8.79	25051.50	
Extended Personal Care Rural Differential Tier 2	15 min.	2	950.00	10.34	19646.00	
Extended Personal Care Rural Differential Tier 3	15 min.	1	950.00	11.52	10944.00	
Extended Personal Care	15 min.	15	950.00	6.55	93337.50	
Family Personal Care Total:						1822306.64
Family Personal Care					1822306.64	
GRAND TOTAL:						11910570.08
Total Estimated Unduplicated Participants:						537
Factor D (Divide total by number of participants):						22179.83
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Daily	101	308.00	58.58		
Home Delivered Meals Total:						40934.30
Home Delivered Meals	Per Meal	22	199.00	9.35	40934.30	
Non-Medical Transportation Total:						14699.16
Non-Medical Transportation	Trip	21	38.00	18.42	14699.16	
Specialized Equipment & Supplies Total:						17094.20
Specialized Equipment & Supplies	Per Item	5	1.00	3418.84	17094.20	
Supervision Total:						729169.92
Supervision	15 min.	16	17664.00	2.58	729169.92	
Transitional Living Total:						417386.52
Transitional Living Rural Differential Tier 1	15 min.	2	3734.00	9.82	73335.76	
Transitional Living Rural Differential Tier 2	15 min.	1	3734.00	11.37	42455.58	
Transitional Living Rural Differential Tier 3	15 min.	1	3734.00	12.55	46861.70	
Transitional Living	15 min.	9	3734.00	7.58	254733.48	
GRAND TOTAL:						11910570.08
Total Estimated Unduplicated Participants:						537
Factor D (Divide total by number of participants):						22179.83
Average Length of Stay on the Waiver:						279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						14010.10
Adult Day Care	1/2 day	2	169.00	41.45	14010.10	
Adult Residential Care Total:						
GRAND TOTAL:						12853548.02
Total Estimated Unduplicated Participants:						558
Factor D (Divide total by number of participants):						23035.03
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						7449623.36
Adult Residential Care	Daily	152	359.00	136.52	7449623.36	
Case Management Total:						349170.52
Independent Case Management	Monthly	28	4.00	141.94	15897.28	
Agency Case Management	Monthly	423	4.00	196.97	333273.24	
Homemaker Total:						171288.80
Rural Differential Tier 1	15 min.	10	382.00	8.38	32011.60	
Rural Differential Tier 2	15 min.	2	382.00	9.98	7624.72	
Rural Differential Tier 3	15 min.	2	382.00	11.20	8556.80	
Homemaker	15 min.	53	382.00	6.08	123095.68	
Respite Care Total:						450969.28
Rural Differential Tier 1	15 min.	10	863.00	9.05	78101.50	
Rural Differential Tier 2	15 min.	3	863.00	10.65	27572.85	
Rural Differential Tier 3	15 min.	3	863.00	11.87	30731.43	
Respite Care	15 min.	54	863.00	6.75	314563.50	
Supported Employment Total:						15120.16
Supported Employment	15 min.	4	484.00	7.81	15120.16	
Adult Foster Care Total:						290714.58
Adult Foster Care	Daily	13	283.00	79.02	290714.58	
Chore Total:						1195.20
Chore Rural Differential Tier 1	15 min.	1	36.00	9.05	325.80	
Chore Rural Differential Tier 2	15 min.	1	36.00	10.65	383.40	
Chore Rural Differential Tier 3	15 min.	0	36.00	11.87	0.00	
Chore	15 min.	2	36.00	6.75	486.00	
Community Transition Services Total:						580760.80
GRAND TOTAL:						12853548.02
Total Estimated Unduplicated Participants:						558
Factor D (Divide total by number of participants):						23035.03
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
One-Time Transition Cost	Per Item	40	1.00	3254.31	130172.40	
Transition Coordination	15 min.	40	989.00	11.39	450588.40	
Emergency Response Total:						37805.28
Emergency Response	Monthly	102	8.00	46.33	37805.28	
Environmental Modification Total:						20514.28
Environmental Modification	Per Job	4	1.00	5128.57	20514.28	
Extended Personal Care Total:						182448.52
Nurse Education Rural Differential Tier 1	15 min.	3	58.00	17.88	3111.12	
Nurse Education Rural Differential Tier 2	15 min.	2	58.00	19.48	2259.68	
Nurse Education Rural Differential Tier 3	15 min.	1	58.00	20.70	1200.60	
Nurse Education	15 min.	16	58.00	15.58	14458.24	
Extended Personal Care Rural Differential Tier 1	15 min.	3	959.00	9.05	26036.85	
Extended Personal Care Rural Differential Tier 2	15 min.	2	959.00	10.65	20426.70	
Extended Personal Care Rural Differential Tier 3	15 min.	1	959.00	11.87	11383.33	
Extended Personal Care	15 min.	16	959.00	6.75	103572.00	
Family Personal Care Total:						1970076.15
Family Personal Care	Daily	105	311.00	60.33	1970076.15	
Home Delivered Meals Total:						42583.86
Home Delivered Meals	Per Meal	22	201.00	9.63	42583.86	
Non-Medical Transportation Total:						15138.06
Non-Medical Transportation	Trip	21	38.00	18.97	15138.06	
Specialized Equipment & Supplies Total:						21128.40
Specialized Equipment & Supplies	Per Item	6	1.00	3521.40	21128.40	
Supervision Total:						806770.02
Supervision	15 min.	17	17841.00	2.66	806770.02	
GRAND TOTAL:					12853548.02	
Total Estimated Unduplicated Participants:					558	
Factor D (Divide total by number of participants):					23035.03	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Living Total:						434230.65
Transitional Living Rural Differential Tier 1	15 min.	2	3771.00	10.11	76249.62	
Transitional Living Rural Differential Tier 2	15 min.	1	3771.00	11.71	44158.41	
Transitional Living Rural Differential Tier 3	15 min.	1	3771.00	12.93	48759.03	
Transitional Living	Daily	9	3771.00	7.81	265063.59	
GRAND TOTAL:					12853548.02	
Total Estimated Unduplicated Participants:					558	
Factor D (Divide total by number of participants):					23035.03	
Average Length of Stay on the Waiver:						279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						14603.40
Adult Day Care	1/2 day	2	171.00	42.70	14603.40	
Adult Residential Care Total:						8042901.52
Adult Residential Care	Daily	158	362.00	140.62	8042901.52	
Case Management Total:						374028.00
Independent Case Management	Monthly	29	4.00	146.20	16959.20	
Agency Case Management	Monthly	440	4.00	202.88	357068.80	
Homemaker Total:						186380.10
Rural Differential Tier 1	15 min.	11	386.00	8.63	36642.98	
Rural Differential Tier 2	15 min.	2	386.00	10.28	7936.16	
Rural Differential Tier 3	15 min.	2	386.00	11.53	8901.16	
GRAND TOTAL:					13896914.39	
Total Estimated Unduplicated Participants:					580	
Factor D (Divide total by number of participants):					23960.20	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker	15 min.	55	386.00	6.26	132899.80	
Respite Care Total:						509666.56
Rural Differential Tier 1	15 min.	11	872.00	9.32	89397.44	
Rural Differential Tier 2	15 min.	4	872.00	10.97	38263.36	
Rural Differential Tier 3	15 min.	4	872.00	12.22	42623.36	
Respite Care	15 min.	56	872.00	6.95	339382.40	
Supported Employment Total:						19657.80
Supported Employment	15 min.	5	489.00	8.04	19657.80	
Adult Foster Care Total:						327025.02
Adult Foster Care	Daily	14	287.00	81.39	327025.02	
Chore Total:						1230.84
Chore Rural Differential Tier 1	15 min.	1	36.00	9.32	335.52	
Chore Rural Differential Tier 2	15 min.	1	36.00	10.97	394.92	
Chore Rural Differential Tier 3	15 min.	0	36.00	12.22	0.00	
Chore	15 min.	2	36.00	6.95	500.40	
Community Transition Services Total:						602808.40
One-Time Transition Cost	Per Item	40	1.00	3351.94	134077.60	
Transition Coordination	15 min.	40	999.00	11.73	468730.80	
Emergency Response Total:						40475.04
Emergency Response	Monthly	106	8.00	47.73	40475.04	
Environmental Modification Total:						26412.15
Environmental Modification	Per Job	5	1.00	5282.43	26412.15	
Extended Personal Care Total:						199709.52
Nurse Education Rural Differential Tier 1	15 min.	4	58.00	18.42	4273.44	
Nurse Education Rural Differential Tier 2	15 min.		58.00	20.06	2326.96	
GRAND TOTAL:					13896914.39	
Total Estimated Unduplicated Participants:					580	
Factor D (Divide total by number of participants):					23960.20	
Average Length of Stay on the Waiver:						279

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		2				
Nurse Education Rural Differential Tier 3	15 min.	1	58.00	21.32	1236.56	
Nurse Education	15 Min.	16	58.00	16.05	14894.40	
Extended Personal Care Rural Differential Tier 1	15 min.	4	969.00	9.32	36124.32	
Extended Personal Care Rural Differential Tier 2	15 min.	2	969.00	10.97	21259.86	
Extended Personal Care Rural Differential Tier 3	15 min.	1	969.00	12.22	11841.18	
Extended Personal Care	15 min.	16	969.00	6.95	107752.80	
Family Personal Care Total:						2126803.64
Family Personal Care	Daily	109	314.00	62.14	2126803.64	
Home Delivered Meals Total:						46316.48
Home Delivered Meals	Per Meal	23	203.00	9.92	46316.48	
Non-Medical Transportation Total:						16765.32
Non-Medical Transportation	Trip	22	39.00	19.54	16765.32	
Specialized Equipment & Supplies Total:						21762.30
Specialized Equipment & Supplies	Per Item	6	1.00	3627.05	21762.30	
Supervision Total:						888697.08
Supervision	15 min.	18	18019.00	2.74	888697.08	
Transitional Living Total:						451671.22
Transitional Living Rural Differential Tier 1	15 min.	2	3809.00	10.42	79379.56	
Transitional Living Rural Differential Tier 2	15 min.	1	3809.00	12.06	45936.54	
Transitional Living Rural Differential Tier 3	15 min.	1	3809.00	13.32	50735.88	
Transitional Living	15 min.	9	3809.00	8.04	275619.24	
GRAND TOTAL:					13896914.39	
Total Estimated Unduplicated Participants:					580	
Factor D (Divide total by number of participants):					23960.20	
Average Length of Stay on the Waiver:						279