CHAPTER 75-03-23
PROVISION OF HOME AND COMMUNITY-BASED SERVICES UNDER THE SERVICE PAYMENTS FOR ELDERLY AND DISABLED PROGRAM AND THE MEDICAID WAIVER FOR THE AGED AND DISABLED PROGRAM

75-03-23-01. Definitions.

The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 50-06.2. In addition, as used in this chapter:

1. "Activities of daily living" means the daily self-care personal activities that include bathing, dressing or undressing, eating or feeding, toileting, continence, transferring in and out of bed or chair or on and off the toilet, and mobility inside the home.

2. "Adaptive assessment" means an evaluation to identify adaptive devices, equipment, or modifications that enhance the independence and functional capabilities of an individual who may otherwise be unable to remain in the individual's home.

3. "Aged" means sixty-five years of age or older.

4. "Client" means an individual who meets the eligibility requirements and is receiving services reimbursed under North Dakota Century Code chapter 50-06.2 or this chapter.

5. "Congenital disability" means a disability that exists at birth or shortly thereafter, and is not attributable to a diagnosis of either mental retardation or a closely related condition of mental retardation.

6. "Department" means the North Dakota department of human services.

7. "Disability due to trauma" means a disability that results from an injury or assault to the body by an external force.

8. "Disability that is acquired" means a disability that results from an assault that occurs internally within the body.

9. "Disabled" means under age sixty-five with a congenital disability, a disability due to trauma, or a disability that is acquired.

10. "Functional assessment" means an instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, individuals residing with, emergency contacts, medical resources, health care coverage, and source and reason for referral; and to secure measurable information regarding:

    a. Physical health;

    b. Cognitive and emotional functioning;

    c. Activities of daily living;

    d. Instrumental activities of daily living;

    e. Informal supports;

    f. Need for twenty-four-hour supervision;

    g. Social participation;

    h. Physical environment;

    i. Financial resources;

    j. Adaptive equipment;

    k. Environmental modification; and

    l. Other information about the individual's condition not recorded elsewhere.

11. "Functional impairment" means the inability to perform, either by oneself or with adaptive aids or with human help, specific activities of daily living or instrumental activities of daily living.

12. "Home and community-based services" means the array of services under the SPED program and Medicaid waiver defined in the comprehensive human service plan and the other services the department determines to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care.

13. "Institution" means a hospital, swing bed facility, nursing facility, or other provider-operated living arrangement receiving prior approval from the department.

14. "Instrumental activities of daily living" means activities requiring cognitive ability or physical ability, or both. Instrumental activities of daily living include preparing meals, shopping, managing money, housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

15. "Medicaid waiver program" means the federal Medicaid waiver for the aged and disabled program, as defined in subpart G of 42 CFR 441, under which the department is authorized to provide specific home and community-based services to aged and disabled persons who are at risk of being institutionalized.

16. "Service fee" means the amount a SPED client is required to pay toward the cost of the client's SPED services.

17. "Service payment" means the payment issued by the department to a qualified service provider for the provision of authorized home and community-based services to eligible aged and disabled persons.

18. "SPED program" means the service payments for elderly and disabled program, a state program which authorizes the department to reimburse qualified service providers for the provision of covered home and community-based services to eligible aged and disabled individuals.

19. "SPED program pool" means the list maintained by the department which contains the names of clients for whom SPED program funding is available when the clients' names are transferred from the SPED program pool to SPED program active status.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; January 1, 2018.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-02. Eligibility criteria.

1. An applicant must be entered in the SPED program pool before service payments may be authorized. The department shall allow entry into the SPED program pool to occur:

   a. When the department's designee submits a form in the manner prescribed by the department; or

   b. When the applicant meets the special circumstances provided in subsection 4, 5, or 6 of section 75-03-23-03.

2. An applicant's resources may not exceed fifty thousand dollars for the applicant to be eligible for services under the SPED program. For purposes of this section, resources are cash or similar assets that can be readily converted to cash and include residences owned by the applicant other than the applicant's primary residence.

3. An applicant eighteen years of age or older is eligible for the SPED program pool if:

   a. The applicant has a functional impairment as specified by the department in policies and procedures to indicate applicant eligibility;

   b. The applicant's functional impairment has lasted, or can be expected to last, three months or longer;

   c. The applicant's functional impairment is not the result of a mental illness or a condition of mental retardation, or a closely related condition;

   d. The applicant is living in North Dakota in a housing arrangement commonly considered a private residence and not in an institution;

   e. The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan option of personal care services unless the applicant's estimated monthly benefits under this chapter, excluding the cost of case management, are between the current medically needy income level for a household of one plus the disregard established in North Dakota Century Code section 50-24.1-02.3, and the lowest level of the fee schedule for services under North Dakota Century Code chapter 50-06.2, or unless the individual is receiving a service that is not available under Medicaid or the Medicaid waiver;

   f. The applicant would receive one or more of the covered services under department policies and procedures for the specific service;

g. The applicant agrees to the plan of care developed for the provision of home and community-based services;

h. The applicant is not responsible for one hundred percent of the cost of the covered service provided, under the SPED program sliding fee scales based on family size and income; and

i. The applicant has not made a disqualifying transfer of assets.

4. An applicant under eighteen years of age is eligible for the SPED program pool if the applicant is determined to need nursing facility level of care as provided for in section 75-02-02-09 and the applicant's care need is not the result of a mental illness or the condition of mental retardation, or a closely related condition.

5. An applicant under eighteen years of age:

a. Must meet the eligibility requirements of subsections 3 and 4.

b. Is not eligible to receive personal care services under this chapter.

c. Is not eligible for service payments unless:

(1) Care provided to the applicant by the applicant's parent or the applicant's spouse is provided under family home care.

(2) The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.

6. An applicant must be capable of directing self-care or must have a legally responsible party to act on the applicant's behalf.

7. An applicant is not eligible for service payments if the care provided is court-ordered.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-04(3)

75-03-23-03. Eligibility determination - Authorization of services.

1. The department shall provide written notice to the department's designee of the effective date of the applicant's eligibility for services funded under the SPED program.

2. A person transferred to SPED program active status from the SPED program pool shall continue to meet the eligibility criteria of section 75-03-23-02 in order to remain eligible for services funded under the SPED program.

3. The department's designee is responsible for:

a. Verifying that the person transferred to active status continues to meet the eligibility criteria for placement into the SPED program pool;

b. Developing a care plan;

c. Authorizing covered services in accordance with department policies and procedures;

d. Verifying the financial eligibility criteria in relation to income, assets, and deductions; and

e. Assuring that other potential federal and third-party funding sources for similar services are sought first.

4. A recipient of services under the Medicaid waiver program, who becomes ineligible for the Medicaid waiver program because evaluation shows that the recipient no longer requires a nursing facility level of care, does not have to go through the SPED program pool to receive services through the SPED program provided the recipient meets all eligibility criteria in section 75-03-23-02.

5. A recipient of services under the Medicaid personal care service option, who becomes ineligible for services under the Medicaid personal care service option, does not have to go through the SPED program pool to receive services through the SPED program provided the recipient meets all eligibility criteria in section 75-03-23-02.

6. A recipient of services under the expanded service payments for elderly and disabled program, who becomes ineligible for services under the expanded service payments for elderly and disabled program, does not have to go through the SPED program pool to receive services through the SPED program provided the recipient meets all eligibility criteria in section 75-03-23-02.

7. An individual who is discharged from an inpatient hospital stay, skilled nursing facility, swing-bed facility, long-term care facility, or basic care facility or who has been off of the SPED program for fewer than sixty days, does not have to go through the SPED program pool to receive services through the SPED program provided the individual meets all eligibility criteria in section 75-03-23-02.

History: Effective June 1, 1995; amended effective January 1, 2009.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-04. Eligibility criteria for Medicaid waiver program.

An applicant is eligible to receive services funded by the Medicaid waiver program if:

1. The applicant is either aged or disabled, and, if disabled:

   a. The disability must not be the result of mental illness as the primary diagnosis or the result of mental retardation, or a closely related condition; and

   b. The disability must meet the social security administration's definition of disability or the individual must be determined physically disabled by the state review team under section 75-02-02.1-14.

2. The applicant is receiving Medicaid;

3. The applicant is evaluated to be in need of a nursing facility level of care;

4. The applicant's needs may be met by one or more of the covered services, as determined by an assessment conducted in accordance with department policies and procedures;

5. The applicant's service provider is not the applicant's spouse, except when allowed by an approved waiver, or, if the applicant is less than eighteen years old, the applicant's service provider is not the applicant's parent, stepparent, or a person legally responsible for the care of the individual unless allowed by an approved waiver;

6. The applicant agrees to accept services provided under the Medicaid waiver program instead of nursing home care; and

7. The applicant agrees to the plan of care developed for the provision of home and community-based services.

History: Effective June 1, 1995; amended effective January 1, 2009.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-03(6)

75-03-23-05. Services covered under the SPED program - Programmatic criteria.

Room and board costs may not be paid in the SPED service payment. The following categories of services are covered under the SPED program and may be provided to a client:

1. The department may provide adult day care services to a client:

   a. Who requires assistance in activities of daily living or instrumental activities of daily living;

   b. Who is able to participate in group activities; and

   c. Who, if the client does not live alone, has a primary caregiver who will benefit from the temporary relief of care giving.

2. The department may provide adult foster care using a licensed adult foster care provider to a client eighteen years of age or older:

   a. Who resides in a licensed adult foster care home;

   b. Who requires care or supervision;

   c. Who would benefit from a family environment; and

   d. Whose required care does not exceed the capability of the foster care provider.

3. The department may provide chore services to a client for one-time, intermittent, or occasional activities which would enable the client to remain in the home. Activities such as heavy housework and periodic cleaning, professional extermination, snow removal, and emergency response systems may be provided. Clients receiving emergency response services must be cognitively and physically capable of activating the emergency response system. The activity must be the responsibility of the client and not the responsibility of the landlord.

4. The department may provide environmental modification to a client:

   a. Who owns the home to be modified;

   b. When the modification will enable the client to complete the client's own personal care or to receive care and allow the client to safely stay in the home;

   c. When no alternative community resource is available; and

   d. Limited to labor and materials for installing safety rails.

5. a. The department may provide extended personal care services to a client who:

      (1) Requires skilled or nursing care that requires training by a nurse licensed under North Dakota Century Code chapter 43-12.1; and

      (2) Has a cognitive or physical impairment that prevents the client from completing the required activity.

b. Extended personal care services do not include assistance with activities of daily living or instrumental activities of daily living.

6. The department may provide family home care services to a client who:

   a. Lives in the same residence as the care provider on a twenty-four-hour basis;

   b. Agrees to the provision of services by the care provider; and

   c. Is the spouse of the care provider or the current or former spouse of one of the following relatives of the client: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew.

7. The department may provide home and community-based services case management services to a client who needs a functional assessment and the coordination of cost-effective delivery issues. The case management services must be provided by a social worker licensed under North Dakota Century Code section 43-41-04.

8. The department may provide home-delivered meals to a client who lives alone and is unable to prepare an adequate meal for himself or herself, or who lives with an individual who is unable or not available to prepare an adequate meal for the client.

9. The department may provide homemaker services to a client who needs assistance with environmental maintenance activities including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis and who lives alone or with an adult who is unable or is not obligated to perform homemaking activities. The department may not pay a provider for laundry, shopping, housekeeping, meal preparation, money management, or communication, if the provider lives with the client and is a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02, or is a former spouse of the client; except the department may provide essential homemaking activities such as meal preparation if the adult not receiving care who resides in the home is unavailable due to employment. The department may provide shopping assistance only if at least one other activity is performed and no other shopping assistance is available through informal networks or other community providers. The homemaker services funding cap applies to a household and may not be exceeded regardless of the number of clients residing in that household.

10. Nonmedical transportation services may be provided to clients who are unable to provide their own transportation and need transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

11. The department may provide personal care services to a client who needs help or supervision with personal care activities if:

    a. The client is at least eighteen years of age;

    b. The client lives alone or is alone due to the employment of the primary caregiver or the incapacity of other adult household members; and

    c. The services are provided in the client's home or in a provider's home if the provider meets the definition of a relative as defined in subdivision c of subsection 5 of section 75-03-23-05.

12. a. The department may provide respite care services to a client in the client's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

(1) The client has a full-time primary caregiver;

(2) The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

(3) The primary caregiver's need for the relief is intermittent or occasional; and

(4) The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

b. A client who is a resident of an adult foster care may choose a respite provider and is not required to use a relative of the adult foster care provider as the client's respite provider.

13. The department may provide other services as the department determines appropriate.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-06. Services covered under the Medicaid waiver program - Programmatic criteria.

Room and board costs may not be included in the Medicaid waiver service payment. The following services are covered under the Medicaid waiver program and may be provided to a client:

1. The department may provide adult day care services to a client:

   a. Who requires assistance in activities of daily living or instrumental activities of daily living;

   b. Who is able to participate in group activities; and

   c. If the client does not live alone, the client's primary caregiver will benefit from the temporary relief of care giving.

2. The department may provide adult foster care, using a licensed adult foster care provider, to a client who resides in a licensed adult foster care home who:

   a. Is eighteen years of age or older;

   b. Requires care or supervision;

   c. Would benefit from a family environment; and

   d. Requires care that does not exceed the capability of the foster care provider.

3. The department may provide residential care to a client who:

   a. Has chronic moderate to severe memory loss; or

   b. Has a significant emotional, behavioral, or cognitive impairment.

4. The department may provide attendant care to a client who:

   a. Is ventilator-dependent a minimum of twenty hours per day;

   b. Is medically stable as documented at least annually by the client's primary care physician;

   c. Has identified an informal caregiver support system for contingency planning; and

d. Is competent to participate in the development and monitoring of the care plan as documented at least annually by the client's primary care physician.

5. The department may provide chore services to a client for one-time, intermittent, or occasional activities that would enable the client to remain in the home, such as heavy housework and periodic cleaning, professional extermination, and snow removal. The activity must be the responsibility of the client and not the responsibility of the landlord.

6. The department may provide an emergency response system to a client who lives alone or with an incapacitated adult, or who lives with an individual whose routine absences from the home present a safety risk for the client, and the client is cognitively and physically capable of activating the emergency response system.

7. When no alternative community resource is available, the department may provide environmental modification to a client, if the client owns the home to be modified and when the modification will enable the client to complete the client's own personal care or to receive care and will allow the client to safely stay in the home for a period of time that is long enough to offset the cost of the modification.

8. a. The department may provide family personal care to a client who:

(1) Lives in the same residence as the care provider on a twenty-four-hour basis;

(2) Agrees to the provision of services by the care provider; and

(3) Is the legal spouse of the care provider.

b. Family personal care payments may not be made for assistance with the activities of communication, community integration, housework, laundry, meal preparation, money management, shopping, social appropriateness, or transportation.

9. The department may provide home and community-based services case management services to a client who needs a comprehensive assessment and the coordination of cost-effective delivery of services. Case management services provided under this subsection must be provided by a social worker licensed under North Dakota Century Code section 43-41-04.

10. The department may provide home-delivered meals to a client who lives alone and is unable to prepare an adequate meal for himself or herself or who lives with an individual who is unable or not available to prepare an adequate meal.

11. The department may provide homemaker services to a client who needs assistance with environmental maintenance activities, including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis when the client lives alone or with an adult who is unable or is not obligated to complete homemaking activities. The department may not pay a provider for laundry, shopping, housekeeping, meal preparation, money management, or communication, if the provider lives with the client and is a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02, or is a former spouse of the client; except the department may provide essential homemaking activities such as meal preparation if the responsible adult not receiving care who resides in the home is unavailable due to employment. Shopping assistance may be provided only if at least one other activity is performed and no other shopping assistance is available through informal networks or other community providers. The homemaker service funding cap applies to a household and may not be exceeded regardless of the number of clients residing in that household.

12. a. The department may provide extended personal care services to a client who:

(1) Requires skilled or nursing care that requires training by a nurse licensed under North Dakota Century Code chapter 43-12.1; and

(2) Has a cognitive or physical impairment that prevents the client from completing the required activity.

b. Extended personal care services do not include assistance with activities of daily living and instrumental activities of daily living.

13. The department may provide nonmedical transportation services to a client who is unable to provide his or her own transportation and who needs transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

14. The department may provide up to twenty-four hours per day of supervision to a client who has a cognitive or physical impairment that results in the client needing monitoring to assure the client's continued health and safety, if the client lives alone or with an individual who is not a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02.

15. a. The department may provide respite care services to a client in the client's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

(1) The client has a full-time primary caregiver;

(2) The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

(3) The primary caregiver's need for the relief is intermittent or occasional; and

(4) The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

b. A client who is a resident of an adult foster care home may choose a respite provider and is not required to use a relative of the adult foster care provider as the client's respite provider.

16. The department may provide specialized equipment and supplies to a client, if:

a. The client's need for the items is based on an adaptive assessment;

b. The items directly benefit the client's ability to perform personal care or household activities;

c. The items will reduce the intensity or frequency of human assistance required to meet the client care needs;

d. The items are necessary to prevent the client's institutionalization;

e. The items are not available under the Medicaid state plan; and

f. The client is motivated to use the item.

17. The department may provide supported employment to a client who is unlikely to obtain competitive employment at or above the minimum wage; who, because of the client's disabilities, needs intensive ongoing support to perform in a work setting; and who has

successfully completed the supported employment program available through the North Dakota vocational rehabilitation program.

18. The department may provide transitional living services to a client who needs supervision, training, or assistance with self-care, communication skills, socialization, sensory and motor development, reduction or elimination of maladaptive behavior, community living, and mobility. The department may provide these services until the client's independent living skills development has been met or until an interdisciplinary team determines the service is no longer appropriate for the client.

19. The department may provide community transition services to a client who is 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 nonrecurring set-up expenses. Community transition services include one-time transition costs and transition coordination.

    a. Allowable expenses are those necessary to enable a client to establish a basic household that do not constitute room and board and may include:

        (1) Security deposits that are required to obtain a lease on a private residence;

        (2) Essential household furnishings required to occupy and use a private residence, including furniture, window coverings, food preparation items, and bed and bath linens;

        (3) Setup fees or deposits for utility or service access, including telephone, electricity, heating, and water;

        (4) Services necessary for the client's health and safety, such as pest eradication and one-time cleaning prior to occupancy;

        (5) Moving expenses;

        (6) Necessary home accessibility adaptations; and

        (7) Activities to assess need and to arrange for and procure need resources.

    b. Community transition services do not include monthly rental or mortgage expenses, escrow, specials, insurance, food, regular utility or service access charges, household appliances, or items that are intended for purely diversional or recreational purposes.

    c. Community transition services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the client is unable to meet such expense, or when the services cannot be obtained from other sources.

20. The department may provide a nurse assessment to a client who requires an evaluation of his or her health care needs to ensure the health, welfare, and safety of the client. The service is limited to a nurse assessment, consultation, and recommendations to address the health-related need for services that are necessary to support a client in a home- or community-based setting. The service must be provided by an advanced practice registered nurse or a registered nurse who is in good standing.

21. The department may provide other services as permitted by an approved waiver.

22. Subsections 19 and 20 become effective on the effective date of approved amendments to the 1915(c) Medicaid waiver sufficient to secure federal financial participation in the cost of

services provided to individuals found eligible under subsections 19 and 20, remain effective as long as federal financial participation continues to be available and state law authorizes such coverage, and is thereafter ineffective.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-07. Qualified service provider standards and agreements.

1. An individual or agency seeking designation as a qualified service provider shall complete and return the applicable forms supplied by the department in the form and manner prescribed. The qualified service provider, including any employees of an agency designated as a qualified service provider, shall meet all licensure, certification, or competency requirements applicable under state or federal law and departmental standards necessary to provide care to clients whose care is paid by public funds. An application is not complete until the individual or agency submits all required information and required provider verifications to the department.

2. A provider or an individual seeking designation as a qualified service provider:

   a. Must have the basic ability to read, write, and verbally communicate;

   b. Must not be an individual who has been found guilty of, pled guilty to, or pled no contest to:

      (1) An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-17, assaults - threats - coercion - harassment; or 12.1-18, kidnapping; North Dakota Century Code section 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-06, sexual abuse of wards; 12.1-20-06.1, sexual exploitation by therapist; 12.1-20-07, sexual assault; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; North Dakota Century Code chapter 12.1-27.2, sexual performances by children; or North Dakota Century Code section 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering a vulnerable adult; 12.1-31-07.1, exploitation of a vulnerable adult; subsection 1 of section 26.1-02.1-02.1, fraudulent insurance acts; or an offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the enumerated North Dakota statutes; except that a person found guilty of misdemeanor simple assault described in North Dakota Century Code section 12.1-17-01, or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction may be considered rehabilitated if the requirements of subparagraph a or b of paragraph 2 of subdivision b of subsection 2 are met; or

      (2) An offense, other than a direct-bearing offense identified in paragraph 1 of subdivision b of subsection 2, if the department determines that the individual has not been sufficiently rehabilitated.

         (a) The department may not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment without subsequent charge or conviction has elapsed, or sufficient evidence is provided of completion of any relevant rehabilitation program.

(b) An individual's completion of a period of three years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation;

c. Must not have an infectious or contagious disease, according to the centers for disease control and prevention's personnel health guidelines, and shall demonstrate any related infection control skills;

d. Shall maintain confidentiality;

e. Shall submit a request to be a qualified service provider every twenty-four months using applicable forms and shall provide documentation as required by the department;

f. Must be physically capable of performing the service for which they were hired;

g. Must be at least eighteen years of age; and

h. Must not have been the subject of a child abuse or neglect assessment for which a services required decision was made unless the program administrator, after appropriate consultation with persons qualified to evaluate the capabilities of the provider, documenting criteria used in making the decision, and imposing any restrictions necessary, approves the request, provided the provider can demonstrate:

(1) The successful completion of an appropriate therapy; or

(2) The elimination of an underlying basis precipitating the neglect or abuse.

3. If the physical, cognitive, social, or emotional health capabilities of an applicant or provider appear to be questionable, the department may require the applicant or provide to present evidence of the applicant's or provider's ability to provide the required care based on a formal evaluation. The department is not responsible for costs of any required evaluation.

4. The offenses enumerated in paragraph 1 of subdivision b of subsection 2 have a direct bearing on an individual's ability to be enrolled as a qualified service provider.

a. An individual enrolled as a qualified service provider prior to January 1, 2009, who has been found guilty of, pled guilty to, or pled no contest to, an offense considered to have a direct bearing on the individual's ability to provide care may be considered rehabilitated and may continue to provide services if the individual has had no other offenses and provides sufficient evidence of rehabilitation to the department.

b. The department may not approve, deny, or renew an application for an individual or employee of an agency who is applying to enroll or re-enroll as a qualified service provider and who has been charged with an offense considered to have a direct bearing on the individual's ability to provide care or an offense in which the alleged victim was under the applicant's care, until final disposition of the criminal case against the individual.

5. Evidence of competency for adult foster care providers serving clients eligible for the developmental disability waiver must be provided in accordance with subdivision b of subsection 2 of section 75-03-21-08.

6. A provider of services for adult day care, adult foster care, attendant care, extended personal care, family personal care, nurse assessment, personal care, residential care, respite care, supervision, and transitional living care shall provide evidence of competency in generally accepted procedures for:

a. Infection control and proper handwashing methods;

b. Handling and disposing of body fluids;

c. Tub, shower, and bed bathing techniques;

d. Hair care techniques, sink shampoo, and shaving;

e. Oral hygiene techniques of brushing teeth and cleaning dentures;

f. Caring for an incontinent client;

g. Feeding or assisting a client with eating;

h. Basic meal planning and preparation;

i. Assisting a client with the self-administration of medications;

j. Maintaining a kitchen, bathroom, and other rooms used by a client in a clean and safe condition, including dusting, vacuuming, floor care, garbage removal, changing linens, and other similar tasks;

k. Laundry techniques, including mending, washing, drying, folding, putting away, ironing, and related work;

l. Assisting a client with bill paying and balancing a check book;

m. Dressing and undressing a client;

n. Assisting with toileting;

o. Routine eye care;

p. Proper care of fingernails;

q. Caring for skin, including giving a back rub;

r. Turning and positioning a client in bed;

s. Transfer using a belt, standard sit, or bed to wheelchair;

t. Assisting a client with ambulation; and

u. Making wrinkle-free beds.

7. An applicant for qualified service provider status for attendant care, adult foster care, extended personal care, family personal care, nurse assessment, personal care, residential care, supervision, transitional living care, respite care, or adult day care must secure written verification that the applicant is competent to perform procedures specified in subsection 5 from a physician, chiropractor, registered nurse, licensed practical nurse, occupational therapist, physical therapist, or an individual with a professional degree in specialized areas of health care. Written verification of competency is not required if the individual holds one of the following licenses or certifications in good standing: physician, physician assistant, chiropractor, registered nurse, licensed practical nurse, registered physical therapist, registered occupational therapist, or certified nurse assistant. A certificate or another form of acknowledgment of completion of a program with a curriculum that includes the competencies in subsection 5 may be considered evidence of competence.

8. The department may approve global and client-specific endorsements to provide particular procedures for a provider based on written verification of competence to perform the procedure from a physician, chiropractor, registered nurse, occupational therapist, physical therapist, or other individual with a professional degree in a specialized area of health care or approved within the scope of the individual's health care license or certification.

9. Competence may be demonstrated in the following ways:

   a. A demonstration of the procedure being performed;

   b. A detailed verbal explanation of the procedure; or

   c. A detailed written explanation of the procedure.

10. The department shall notify the individual or the agency of its decision on designation as a qualified service provider.

11. The department shall maintain a list of qualified service providers. Once the client's need for services has been determined, the client selects a provider from the list and the department's designee issues an authorization to provide services to the selected qualified service provider.

12. A service payment may be issued only to a qualified service provider who bills the department after the delivery of authorized services.

History: Effective June 1, 1995; amended effective March 1, 1997; January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-08. Termination of qualified service provider status and denial of application to become a qualified service provider.

1. The department may terminate a qualified service provider if:

   a. The qualified service provider voluntarily withdraws from participation as a qualified service provider;

   b. The qualified service provider is not in compliance with applicable state laws, state regulations, or program issuances governing providers;

   c. The qualified service provider is not in compliance with the terms set forth in the application or provider agreement;

   d. The qualified service provider is not in compliance with the provider certification terms on the claims submitted for payment;

   e. The qualified service provider has assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32);

   f. The qualified service provider has demonstrated a pattern of submitting inaccurate billings or cost reports;

   g. The qualified service provider has demonstrated a pattern of submitting billings for services not covered under department programs;

   h. The qualified service provider has been debarred or the provider's license or certificate to practice in the provider's profession or to conduct business has been suspended or terminated;

i. The qualified service provider has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals;

j. The qualified service provider has been convicted of an offense determined by the department to have a direct bearing upon the provider's ability to be enrolled as a qualified service provider, or the department determines, following conviction of any other offense, the provider is not sufficiently rehabilitated;

k. The qualified service provider is currently excluded from participation in Medicare, Medicaid, or any other federal health care program;

l. The qualified service provider has not provided sufficient evidence to the department, after obtaining a formal evaluation under subsection 3 of section 75-03-23-07 that the provider is physically, cognitively, socially, or emotionally capable of providing the care;

m. The qualified service provider has been the subject of a child abuse or neglect assessment for which a services required decision was made and the department has determined the provider does not meet the standards to enroll;

n. There has been no billing activity within the twelve months since the provider's enrollment or most recent reenrollment date; or

o. For other good cause.

2. The department may deny an application to become a qualified service provider if:

a. The applicant voluntarily withdraws the application;

b. The applicant is not in compliance with applicable state laws, state regulations, or program issuances governing providers;

c. The applicant, if previously enrolled as a qualified service provider, was not in compliance with the terms set forth in the application or provider agreement;

d. The applicant, if previously enrolled as a qualified service provider, was not in compliance with the provider certification terms on the claims submitted for payment;

e. The applicant, if previously enrolled as a qualified service provider, had assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32);

f. The applicant, if previously enrolled as a qualified service provider, had demonstrated a pattern of submitting inaccurate billings or cost reports;

g. The applicant, if previously enrolled as a qualified service provider, had demonstrated a pattern of submitting billings for services not covered under department programs;

h. The applicant has been debarred or the applicant's license or certificate to practice in the applicant's profession or to conduct business has been suspended or terminated;

i. The applicant has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals;

j. The applicant has been convicted of an offense determined by the department to have a direct bearing upon the applicant's ability to be enrolled as a qualified service provider, or the department determines, following conviction of any other offense, the applicant is not sufficiently rehabilitated;

k. The applicant, if previously enrolled as a qualified service provider, owes the department money for payments incorrectly made to the provider;

l. The qualified service provider is currently excluded from participation in Medicare, Medicaid, or any other federal health care program;

m. The applicant has not provided sufficient evidence to the department, after obtaining a formal evaluation under subsection 3 of section 75-03-23-07, that the applicant is physically, cognitively, socially, or emotionally capable of providing the care;

n. The applicant has been the subject of a child abuse or neglect assessment for which a services required decision was made and the department has determined the applicant does not meet the standards to enroll;

o. The applicant previously has been terminated for inactivity and does not have a prospective public pay client;

p. The applicant previously has been terminated for inactivity and has not provided valid reason for the inactivity; or

q. For other good cause.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-09. Payment under the SPED program and the Medicaid waiver program.

1. The department shall establish provider rates for home and community-based service in accordance with a procedure that factors in:

   a. Whether a provider is an individual or an agency; and

   b. The range of rates submitted by various providers.

2. The rate for a specific qualified service provider is established at the time the provider agreement is signed.

3. The department shall grant a request for a rate decrease when the department receives a written request for the decrease from the qualified service provider.

4. The department shall grant in full or in part, or shall deny, a request for a rate increase when the department receives a written request for the rate increase from the qualified service provider.

5. The department shall determine the maximum amount allowable per client each month for a specific service.

6. The department shall establish the aggregate maximum amount allowable per client each month for all services. The aggregate maximum amount per client depends on whether the client is receiving services under the SPED program, under the Medicaid waiver program, or under both programs.

7. The department or designee may grant approval to exceed the monthly service program maximum for a specific client who is only receiving SPED funds and no Medicaid funds if the client has a special or unique circumstance; the SPED client is not eligible for Medicaid; and the need for additional service program funds will not initially exceed three months. Under

emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

8. The department may grant approval to exceed the monthly service program maximum for a specific client who is receiving SPED funds and Medicaid funds or only Medicaid funds if the client has a special or unique circumstance; and the need for additional service program funds does not exceed three months. Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

9. The department's designee shall notify the client of the department's determination regarding the request to exceed the monthly service program maximum. If the department denies the request to exceed the monthly aggregate maximum, the department's designee shall inform the client in writing of the reason for the denial, the client's right to appeal, and the appeal process, as provided in chapter 75-01-03.

10. The department will grant approval to exceed the monthly program maximum or service maximum for individuals receiving SPED funds or Medicaid funds, or both, whose service units exceed the program caps as a result of the qualified service provider rate increase. This extension is limited to individuals who were receiving services prior to July 1, 2007.

History: Effective June 1, 1995; amended effective September 27, 2007; January 1, 2009.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-10. Department to recover funds upon establishment of noncompliance.

A qualified service provider shall not submit a claim for payment or receive service payments for services that have not been delivered in accord with department policies and procedures. The department shall recover all payments received by a qualified service provider who fails to deliver the services in accord with the provider agreement or department policy and procedure.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6)

75-03-23-11. Denial, reduction, and termination of services - Appeal.

1. The department's designee shall inform a person who is determined to be ineligible for covered services or who becomes ineligible while receiving services in writing of the denial, termination, or reduction, the reasons for the denial, termination, or reduction, the right to appeal, and the appeal process as provided in chapter 75-01-03.

2. A client must receive ten calendar days' written notice before termination of services occurs. The ten-day notice is not required if:

   a. The client enters a basic care facility or a nursing facility;

   b. The termination is due to changes in federal or state law;

   c. The client requests termination of services; or

   d. The client moves from the service area.

3. An applicant denied services or a client terminated from services should be given an appropriate referral to other public or private service providers and should be assisted in finding other resources.

4. For denial or termination of services, a review of the decision by the county social service board director or the designee may be requested. A request for review does not change the time within which the request for an appeal hearing must be filed.

5. The department shall deny or terminate SPED program and Medicaid waiver program services when service to the client presents an immediate threat to the health or safety of the client, the provider of services, or others or when services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others. Examples of health and safety threats include physical abuse of the provider by the client, client self-neglect, an unsafe living environment for the client, or contraindicated practices, like smoking while using oxygen.

History: Effective June 1, 1995; amended effective January 1, 2009.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6), 50-06.2-04(1), 50-06.2-04(3)

75-03-23-12. Provider - Request for review.

1. A qualified service provider may request a review of a decision made by the department regarding provider reimbursement.

2. A qualified service provider who requests a review of a decision regarding provider reimbursement under this section must do so in writing within ten days of the date the qualified service provider was notified of the determination by the department. The written notice must identify each disputed item and the reason or basis for the dispute. A provider may not request a review under this section of the rate paid for each disputed item.

3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits, and other written information that supports the provider's request for review.

4. The department shall assign a provider's request for review to someone other than an individual who was involved in the initial disputed decision.

5. The department shall make and issue its final decision within seventy-five days of the date the department received the notice of request for review.

6. A provider may contact the department employee who made the disputed decision for an informal conference regarding the disputed decision any time before that provider submits a formal request for review to the department.

History: Effective January 1, 2009.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

75-03-23-13. Provider - Appeals.

An applicant or provider may appeal a decision to deny or revoke a qualified service provider enrollment by filing a written appeal with the department within ten days of receipt of written notice of the denial or revocation. Upon receipt of a timely appeal, an administrative hearing may be conducted in the manner provided in chapter 75-01-03. A provider or applicant who receives notice of termination or denial of the individual's qualified service provider status and requests a timely review of that decision is not eligible to provide services until a final decision has been made by the department that reverses the decision to terminate or deny qualified service provider status.

History: Effective January 1, 2009.
General Authority: NDCC 50-06.2-03

Law Implemented: NDCC 50-06.2-03

75-03-23-14. Disqualifying transfers.

1. An individual is not eligible for SPED benefits under this chapter if the department determines that the individual or the spouse of the individual has made any assignment or transfer of any asset for the purpose of making the individual eligible for benefits before or after making application for SPED services except as provided in subsection 2.

2. An individual is not ineligible for SPED benefits under this chapter by reason of subsection 1 to the extent that:

   a. The value of the transferred assets when added to the value of the individual's other assets would not otherwise make the individual ineligible for SPED or does not decrease the individual's service fee.

   b. The asset transferred was a home, and title to the home was transferred to:

      (1) The individual's spouse; or

      (2) The individual's son or daughter who is under the age of twenty-one or who is blind or disabled.

   c. The assets:

      (1) Were transferred to the individual's spouse or to another person for the sole benefit of the individual's spouse; or

      (2) Were transferred from the individual's spouse to another person for the sole benefit of the individual's spouse.

   d. The individual makes a satisfactory showing that:

      (1) The individual intended to dispose of the assets at fair market value or for other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

      (2) The assets were transferred exclusively for a purpose other than to qualify for SPED benefits under this chapter; or

      (3) All assets transferred for less than fair market value have been returned to the individual.

   e. If a disqualifying transfer occurred five years prior to the date an individual initially applies for SPED services, the department will presume that the transfer was not for the purpose of obtaining SPED benefits.

3. There is a presumption that a transfer was made for purposes of making an individual eligible for SPED services under this chapter:

   a. If an inquiry about SPED benefits or benefits under this chapter was made, by or on behalf of the individual to any other individual, before the date of transfer;

   b. If the individual or the individual's spouse was an applicant for or recipient of SPED benefits under this chapter before the date of transfer;

c. If a transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets, would exceed SPED asset limits; or

d. If the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

4. An applicant or recipient who claims that assets were transferred exclusively for a purpose other than to qualify for SPED benefits under this chapter must show a desire to receive SPED benefits under this chapter played no part in the decision to make the transfer and must rebut any presumption arising under subsection 3.

5. If the transferee of any assets is the child, grandchild, brother, sister, niece, nephew, parent, grandparent, stepparent, stepchild, son-in-law, daughter-in-law, or grandchild-in-law of the individual or the individual's spouse, services or assistance furnished by the transferee to the individual or the individual's spouse may not be treated as consideration for the transferred asset unless the transfer is made pursuant to a valid written contract entered into prior to rendering the services.

6. A transfer is complete when the individual, or the individual's spouse, making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

7. For purposes of this section, fair market value is received:

   a. When one hundred percent of apparent fair market value is received for an asset whose value is not subject to reasonable dispute, such as cash, bank deposits, stocks, and fungible commodities;

   b. When seventy-five percent of estimated fair market value is received for an asset whose value may be subject to reasonable dispute; and

   c. When one hundred percent of fair market value is received for an asset considered to be income to the individual or individual's spouse.

8. If an applicant or client is denied Medicaid based on a disqualifying transfer of assets, the SPED applicant or client is also ineligible for SPED-funded services.

History: Effective January 1, 2009.
General Authority: NDCC 50-06.2-07
Law Implemented: NDCC 50-06.2-07

75-03-23-15. Application - Applicant required to provide proof of eligibility.

1. An individual wishing to apply for benefits under this chapter must have the opportunity to do so, without delay.

2. An application is a request made to the department or its designee by an individual seeking services under this chapter, or by an individual properly seeking services on behalf of another individual. "An individual properly seeking services" means an individual of sufficient maturity and understanding to act responsibly on behalf of the individual for whom services are sought.

3. An application must include a functional assessment.

4. The individual seeking services under this chapter, or an individual properly seeking services on behalf of that individual, shall sign the application.

5. The department or its designee shall provide information concerning eligibility requirements, available services, and the rights and responsibilities of individuals seeking services under this chapter and of recipients to all who require it.

6. The date of application is the date the department or the department's designee receives the properly signed application.

7. The individual seeking services under this chapter shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and other information required under this chapter.

History: Effective October 1, 2014.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

75-03-23-16. Reapplication after denial or termination.

A provider or applicant whose qualified service provider status has been terminated or denied may not reapply if:

1. The provider's or applicant's status as a qualified service provider has been denied or revoked within the twelve months prior to the date of the current application; or

2. The provider's or applicant's status as a qualified service provider has been denied or revoked three or more times and the most recent revocation or denial occurred within the three years immediately preceding the application date.

History: Effective October 1, 2014.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

75-03-23-17. Functional assessment.

1. An initial functional assessment, using the form required by the department, must be completed as a part of the application for benefits under this chapter. A functional assessment must be completed at least semiannually in conjunction with the eligibility redetermination.

2. The functional assessment must include an interview with the individual in the home where the individual resides.

History: Effective October 1, 2014.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03