1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for

1. Care Coordination
2. Training and Supports for Unpaid Caregivers
3. Peer Support
4. Family Peer Support
5. Respite
6. Non-Medical Transportation
7. Community Transition Services
8. Benefits Planning Services
9. Supported Education
10. Pre-Vocational Training
11. Supported Employment
12. Housing Supports

Individuals with Behavioral Health Conditions as set forth below.

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*: The identified MCO administrative functions are not new duties. These functions have been added to align the MCO's processes with the State's existing processes. The MCO will perform these functions solely for its enrollees, while the State will continue to perform them for fee-for-service beneficiaries.

3. *Select one*:

	Not applicable	
X	**Applicable**	
	Check the applicable authority or authorities:	
	☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** *Specify:* *(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 specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
		N/A

		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)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☒	§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 §1115 of the Act. *Specify the program*:

N/A

4. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (*select one)*:	
	● The Medical Assistance Unit *(name of unit)*:	Medical Services Division
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	N/A
○	The State plan HCBS benefit is operated by *(name of agency)*	
	N/A	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority isavailable through the Medicaid agency to CMS upon request.	

5. Distribution of State plan HCBS Operational and Administrative Functions.

X (By checking this box, the state assures that): While the Medicaid division does not directly conduct an administrative 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 division. When a function is performed by a division/entity other than the Medicaid division, the division/entity performing that function does not substitute its own judgment for that of the Medicaid division with respect to the application of policies, rules and regulations. Furthermore, the Medicaid division assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*)

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	●	☐	☐	●
2 Eligibility evaluation	●	☐	☐	●
3 Review of participant service plans	●	☐	☒	☐
4 Prior authorization of State plan HCBS	●	☐	☒	☐
5 Utilization management	●	☐	☒	☐
6 Qualified provider enrollment	●	☐	☒	☐
7 Execution of Medicaid provider agreement	●	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	●	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	●	☐	☒	☐
10 Quality assurance and quality improvement activities	●	☐	☒	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The State Medicaid Agency retains ultimate authority and responsibility for the operation of the 1915(i) state plan benefit by exercising oversight over the performance of functions, contracted entities, and local non-state entities. The Medical Services Division, within the North Dakota Department of Health and Human Services (NDDHHS) is the single State Medicaid Agency.

The Medical Services Division maintains authority and oversight of 1915(i) operational and administrative functions. Any functions not performed directly by the State Medicaid Agency must be delegated in writing. When the State Medicaid Agency does not directly conduct an operational or administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

The identified MCO administrative functions are not new duties. These functions have been added to align the MCO's processes with the State's existing processes. The MCO will perform these functions solely for its enrollees, while the State will continue to perform them for fee-for-service beneficiaries.

When a function is performed by an entity other than the State Medicaid Agency, the entity performing that function does not substitute its own judgment for that of the State Medicaid Agency with respect to the application of policies, rules and regulations. Furthermore, the State Medicaid Agency assures that it maintains accountability for the performance of any contractualentities or local non-state entities performing operational or administrative functions, e.g., the Fiscal Agent or the Human Service Zones.

Identified employees of the Human Service Zones will directly perform the following operational and administrative functions:

- #1 Individual State Plan HCBS enrollment
- #2 Eligibility Evaluation and Reevaluation

The Human Service Zones provide oversight of their local offices in the counties (*formerly known as county social service offices*). The counties have professionals on site who can help people apply for a variety of services and supports: Supplemental Nutrition Assistance Program (SNAP/Food Stamps), Temporary Assistance for Needy Families (TANF), heating assistance, Medicaid, including children's health insurance program ; basic care assistance; child care assistance; in-home and community-based services and supports for elderly and disabled individuals; personal care assistance; child welfare (foster care, child protection services, child care licensing and related services); and referrals to other local resources and programs.

Employees of the Human Service Zones are county government employees. The Human Service Zones conduct eligibility determinations for a wide variety of programs administered by NDDHHS including Medicaid, the Supplemental Nutrition Assistance Program, the Low-Income Heating Assistance Program and Temporary Assistance for Needy Families. The Zones employ eligibility workers who are the main point of contact for individuals who are applying for and receiving assistance through one of the programs. The Zones have offices in every county in the state for ease of access for individuals. For these reasons, the Human Service Zones are ideal entities to provide 1915(i) enrollment, eligibility evaluation, and reevaluation. The Medical Services Division will have a written agreement with the Human Service Zones delegating them to identify qualified employees to provide these functions.

The Medical Services Division and MCO will share the following operational and administrative functions:

- #3 Review of Participant POCs
- #4 Prior authorization of State plan HCBS
- #5 Utilization management
- #6 Qualified Provider Enrollment
- #7 Execution of Medicaid Provider Agreement
- #8 Establishment of Rate Methodology
- #9 Rules, policies, procedures, and information development governing the HCBS benefit
- #10 Quality assurance and quality improvement activities.

The processes North Dakota will employ for operational and administrative functions #1 - #10 are discussed in detail throughout this application.

Medical Services Division, the contracted MCO, and Human Service Zones will collaborate and hold meetings as needed to discuss operational and administrative functions, trends, member appeals,and any other topics that may arise.

Partnerships: This system involves a partnership between the local Human Service Zones, the North Dakota Department of Health and Human Services, informal networks, and consumers/family members. Advocates for consumers have played a significant role in identifying gaps in current f services. When applicable, other State agencies or other Department of Health and 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 to identifying service needs are: Independent Living Centers, current and potential consumers, family members, and other service providers.

(By checking the following boxes, the State assures that):

6. ● **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensures, at a minimum, that persons performing these functions are not:

1. related by blood or marriage to the individual, or any paid caregiver of the individual
2. financially responsible for the individual
3. empowered to make financial or health-related decisions on behalf of the individual
4. providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The state opts to allow certain providers of state plan HCBS to also perform assessments and develop POCs for the same recipients to whom they are also providing state plan HCBS in the following situations:

1) Such providers are the only willing and qualified providers within the county in which the individual resides. A list of providers and their geographic areas can be found on the State's website: https://www.hhs.nd.gov/1915i/find-a-provider

2) Such providers are the only willing and qualified providers within the county in which the individual resides who share a common language or cultural background.

To ensure conflict of interest standards are met, Medical Services Division will put the following safeguards in place:

A. Medical Services Division and contracted MCO will prohibit the same professional within an agency from conducting both the assessment and plan of care and providing state plan HCBS, other than care coordination, to the same recipient.
B. Provider agencies providing both assessment and plan development, as well as1915(i) HCBS, will document the use of separate professionals and supervisors for the assessment and Plan of Care development and separate professionals and supervisors for 1915(i) HCBS.

C. A provider agency must provide justification and the member's plan of care must be approved by the Medical Services Division or contracted MCO before billing state plan HCBS for recipients whom they have assessed or created a Plan of Care. The plan of care must indicate that recipients were notified of the conflicts and the dispute resolution process, including appeal rights, and that the client has exercised their right in free choice of provider after notification of the conflict. Medical Services Division or contracted MCO ensures the client has agreed to receive 1915(i) services from the same provider who performed their assessment and developed their Plan of Care. The member signs an acknowledgment on the Plan of Care indicating their free choice of provider.

D. Members who receive state plan HCBS from the same agency that provided the assessment or care plan development, are protected by the following safeguards: fair hearing rights, the ability to change providers, and the ability to request different professionals from within the same agency.

E. Provide direct oversight and periodic evaluation of safeguards.

F. The point of entry to enroll in 1915(i) services is the Human Service Zones. The written agreement between the NDDHHS and the Human Service Zones requires them to notify the individual of their right to choose their care coordination provider and their right to appeal, and to assure the Human Service Zone employee determining eligibility is not related by blood or marriage to the individual/participant; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health related decisions on the individual/participant's behalf.

G. Medical Services Division and contracted MCO will require providers to have written conflict of interest standards and written policy to ensure the independence of persons performing evaluations and assessments and developing the member's plan of care. The person must not be:
    1. related by blood or marriage to the individual, or any paid caregiver of the individual; or
    2. financially responsible for the individual; or
    3. empowered to make financial or health-related decisions on behalf of the individual.

H. During the 1915(i) Medicaid eligibility process, the Human Service Zone will provide the individual with information regarding their rights and responsibilities and opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

I. The individual's Care Coordinator will provide written documentation explaining the individual's right to choose providers for each of the services specified on the POC, and their right to change their Care Coordination provider or any other 1915(i) service provider at any time. The participant selects all service provider(s) from a list of available service providers.

J. Medical Services Division and contracted MCO will engage in quality management activities to promote adherence to service delivery practices, including individual choice and direction in the development of the POC, selection of service providers and preference for service delivery.

K. The individual, and their family or guardian when applicable, will develop and lead the POC Team with assistance from the Care Coordinator. The team consists of service providers, community supports and natural supports.

L. The Medical Services Division and contracted MCO are responsible for authorizing all services included in the plan of care.

M. The Medical Services Division and contracted MCO will require all providers who claim they are the only provider willing and qualified to perform assessments of need and develop plans of care (care coordination) in the county in which the individual resides to submit justification

to the Medical Services Division or contracted MCO to support the assertion. The Medical Services Division and contracted MCO will review the evidence and either approve or deny. All providers rendering both Care Coordination and other 1915(i) services to the same individual will identify on the POC the name of the different individual provider rendering the other 1915(i) services (not care coordination), and include the services they will provide in the Individual Goals & Services portion of the Person-Centered Plan of Care. The Medical Services Division or contracted MCO will confirm the provider is the "only willing and qualified" provider prior to the approval of the Person-Centered Plan of Care.

In addition to the conflict-free measures identified above, the dispute resolutions include:

- The MCO does not cover LTSS services including personal care as part of the benefits package for Medicaid Expansion 21–64-year-olds. The MCO is not involved in performing functional assessments or care coordination, except to the extent that they reimburse providers for claims for care coordination services for Medicaid Expansion members ages 21-64
- Individuals, and families when applicable, are provided with written information concerning their right to choose services and providers, and the following dispute resolution process. If the individual is uncomfortable reporting any problems/concerns to their Care Coordinator, they may contact the Medical Services Division of the North Dakota Department of Health and Human Services by emailing nd1915i@nd.gov, or the North Dakota Protection & Advocacy Project by calling 701-328-2950. Care coordinators will be instructed to remind individuals of this option at their care coordination meeting, and at a minimum of quarterly thereafter.

6. ● **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ● **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ● **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals to Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2025	9/30/2026	950
Year 2			
Year 3			
Year 4			

Year 5			

2. ● **Annual Reporting.** *(By checking this box, the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ● **Medicaid Eligible.** *(By checking this box, the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Level (FPL). (This election does notinclude the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) ofthe Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

The State does not provide State plan HCBS to the medically needy.
● The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(c)(i)(III)of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ● The state does not elect to disregard the requirements at section 1902(a)(10)(c)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

	Directly by the Medicaid agency
X	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Evaluation/reevaluation of eligibility including for the Medicaid Expansion population is delegated by the State Medicaid Agency to theNDDHHS Human Service Zones (Zones). The Zones are government agencies. Zone Eligibility Workers or employees will complete the evaluation/reevaluation of eligibility. The Managed Care Organizations (MCO) does not perform any part in the eligibility/reevaluation process.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Requires one year of work experience involving duties directly related to determining eligibility for human services economic assistance programs. Plus, it requires one of the following: (1) Completion of the eligibility worker one-year certificate program. (2) Completion of 90 semester hours or 135 quarter hours of a bachelor's degree program. (3) Graduation from high school or GED and three years of work experience involving processing of claims, loans, financial eligibility benefits, credit reviews, abstracts, taxes, or housing assistance, or working in the clerical, accounting, bookkeeping, legal, financial, business, teaching, investments/financial planning, computer/data processing fields. (4) Three years of any combination of education and experience listed above. (5) One year of Eligibility Call Center Experience.

The Zone Eligibility Worker or employees, on behalf of the State Medicaid Agency, will verify the completed evaluation/reevaluation assessment and use this information to determine eligibility.

To ensure integrity of the process, Zone Eligibility Workers or employees will complete initial and ongoing training conducted by the State Medicaid Agency. Training will provide guidance on the requirements and responsibilities of 1915(i) evaluation/ reevaluation.

World Health Organization Disability Assessment Schedule (WHODAS) administrators must meet the requirements of a "trained, qualified practitioner" as defined by the state. North Dakota has defined a trained, qualified practitioner as: *An independent agent who has reviewed the 1915(i) WHODAS policy, and associated training on the administration and scoring of the WHODAS 2.0* located on the 1915(i) website and in the official WHODAS 2.0 Manual.

Daily Living Activities (DLA) administrators must meet the requirements of a "trained, qualified practitioner" as defined by the state.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to makethis determination. If the reevaluation process differs from the evaluation process, describe the differences:

The evaluation/reevaluation process includes the assessment, and eligibility determination.

North Dakota has identified the World Health Organization Disability Assessment Schedule (WHODAS) and the Daily Living Activities (DLA-20) as the tools for assessment of needs-based eligibility.

Should the results of the new Daily Living Assessment 20 (DLA) tool be that an individual is not eligible for the 1915(i) benefit, the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 assessment will be administered. Should the WHODAS 2.0 assessment demonstrate that the individual is eligible for the 1915(i) benefit, the state will approve the application or grant continued participation for those already enrolled in the benefit.

Also, should the results of the DLA tool be that an individual needs a lesser amount of service, the individual's service amounts will not be decreased unless and until the WHODAS 2.0 is administered to confirm the need for less services. The amount of the service reduction will be in accordance with the WHODAS should the assessments be in dispute.

In summary, the WHODAS and DLA will be utilized because they are:

- valid assessment tools;
- instruments to measure health and determine the level of need of an individual;
- currently utilized in other areas throughout NDDHHS Behavioral Health system;
- used across all diseases, including mental, neurological and addictive disorders;
- applicable in HCBS settings;
- tools to identify standardized need levels;
- applicable across cultures, in all populations across the lifespan;

The Daily Living Activities (DLA-20) is a tool that contains 20 daily activities that are affected by mental health and disability. This functional assessment helps behavioral health providers determine the measure of an outcome, showing where treatment is needed.

The DLA will serve dual purposes for the 1915(i):

1. The DLA assesses an individual's level of need in the following activities:
   - Alcohol and drug abuse
   - Behavioral norms
   - Communication
   - Community
   - Coping mechanisms
   - Dressing
   - Grooming
   - Health practices
   - Housing stability
   - Leisure
   - Money management
   - Nutrition
   - Personal hygiene

- Problem-solving
- Productivity
- Relationships
- Safety
- Sexual life
- Social networks
- Time management

The DLA activity scores will be considered in the person-centered POC planning process to determine, based on need, which of the 1915(i) services the individual would benefit from to reach their goals.

2. The DLA will also provide a reliable overall score to ensure the individual meets the established needs-based eligibility criteria of the 1915(i). A score of 5 or lower is required for 1915(i) eligibility.

The WHODAS is a multi-faceted tool and will serve dual purposes for the 1915(i):

1. The WHODAS will assess an individual's level of need, and assign a score, in each of the 6 Domains:
    - Cognition – understanding & communicating
    - Mobility– moving & getting around
    - Self-care– hygiene, dressing, eating & staying alone
    - Getting along– interacting with other people
    - Life activities– domestic responsibilities, leisure, work & school
    - Participation– joining in community activities

    The domain scores will be considered in the person-centered POC planning process to determine, based on need, which of the 1915(i) services the individual would benefit from to reach their goals.

2. The WHODAS will also provide a reliable overall complex score to ensure the individual meets the established needs-based eligibility criteria of the 1915(i). A comprehensive complex score of 25 or above is required for 1915(i) eligibility.

Modes of Administering the WHODAS 2.0:

The 1915(i) will use two modes of administering WHODAS 2.0: by interview and by proxy, both of which are discussed below. Agents administering the WHODAS by interview must be independent and meet qualifications determined by the State Medicaid Agency. The agents administering the WHODAS will not directly provide HCBS to the individual.

1. **Interview:** WHODAS 2.0 will be administered face-to-face by an agent who is independent and qualified as defined by the state in this application, using a person-centered process.

    General interview techniques are sufficient to administer the interview in this mode. Chapter 7 of the WHODAS Instruction Guide, available through the World Health Organization (WHO) contains question-by-question specifications that each interviewer must be trained in, and chapter 10 contains a test that can be used to assess knowledge related to administration of the WHODAS 2.0.

2. **Proxy:** An individual's representative may provide a third-party view of functioning under the following circumstances:

    Individual's representative means, with respect to an individual being evaluated for, assessed regarding, or receiving State plan HCBS, the following:

(a) The individual's legal guardian or other person who is authorized under State law to represent the individual for the purpose of making decisions related to the person's care or well-being.

(b) Any other person who is authorized under § 435.923, or under the policy of the State Medicaid Agency to represent the individual, including but not limited to, a parent, a family member, or an advocate for the individual.

The applicant, at the time of application and at other times, is permitted to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications. Such a designation must include the applicant's signature.

When the State Medicaid Agency authorizes representatives in accordance with paragraph (b) of this section, the State Medicaid Agency will have policies describing the process for authorization; the extent of decision-making authorized; and safeguards to ensure that the representative uses substituted judgment on behalf of the individual. State Medicaid Agency policy will address exceptions to using substituted judgment when the individual's wishes cannot be ascertained or when the individual's wishes would result in substantial harm to the individual. States may not refuse the authorized representative that the individual chooses, unless in the process of applying the requirements for authorization, the State discovers and can document evidence that the representative is not acting in accordance with these policies or cannot perform the required functions.

The State Medicaid Agency will continue to meet the requirements regarding the person-centered planning process at § 441.725, by requiring the coordinator to develop a written Person-Centered Plan of Care jointly with the individual, and the individual's authorized representative if applicable.

Modes of Administering the DLA

The Daily Living Activities (DLA) assessment is administered in a face-to-face setting at designated Human Service Centers. During this process, a trained and qualified practitioner conducts a structured interview with the individual, systematically asking questions about their ability to perform essential tasks such as personal hygiene, dressing, mobility, and other routine activities. The interviewer not only records responses but also observes and evaluates the individual's performance following standardized scoring protocols. This direct administration ensures that the assessment is both reliable and objective, providing a measure to determine eligibility for Medicaid's 1915(i) home and community-based services program, while allowing professional judgment to clarify or expand on the standard criteria when necessary. Typically, the individual (client) serves as the primary source of information; however, in certain cases—such as when the client is unable to provide a comprehensive account—a proxy may be utilized, either instead of or in addition to the client's account.

Modes of scoring the WHODAS 2.0 Scoring Process

The WHODAS offers several scoring options, however, the Medical Services Division will require assessors to use the Complex scoring method. The more complex method of scoring is called "item-response- theory" (IRT) based scoring; it considers multiple levels of difficulty for each WHODAS 2.0 item. This type of scoring for WHODAS 2.0 allows for more fine-grained analyses that make use of the full information of the individual's responses. The Complex Scoring method takes the coding for each item response as "none", "mild", "moderate", "severe"and "extreme" separately, and then uses a computer to determine the summary score by differentially weighting the items and the levels of severity. Basically, the scoring has three steps:

• Step 1 – Summing of recoded item scores within each domain. • Step 2 – Summing of all six domain scores. • Step 3 – Converting the summary score into a metric ranging from 0 to 100 (where 0 = no disability; 100 = full disability). The computer program is available from the WHO web site.

The WHODAS 2.0 domain scores produce domain-specific scores for six different functioning domains –cognition, mobility, self-care, getting along, life activities (household and work) and participation. The domain scores provide more detailed information than the summary score.

The World Health Organization confirmed the existing WHODAS 2.0 is suitable for individuals across the lifespan. In those cases where a given question may not be applicable, for example in the case of a small child, there is a mechanism outlined in the WHODAS user manual for how to calculate the score when having dropped a question or two. NDDHHS will provide the template for the child's WHODAS administration and scoring to the Zones to ensure state-wide consistency.

For further information on the WHODAS, please see the World Health Organization's website for WHODAS: https://www.who.int/classifications/icf/whodasii/en/

Modes of scoring the DLA

The Daily Living Activities (DLA) instrument is scored using a standardized seven-point scale for each of its twenty items, with each point corresponding to a specific level of functional ability relative to the general population. In this scoring mode, DLA administrators evaluate an individual's performance over the past 30 days on various activities—such as personal hygiene, dressing, safety, and communication—and assign a score that reflects the degree of dependence or independence. A score of 1 reflects extremely severe impairment and total dependence, necessitating continuous and pervasive support, while a score of 7 represents optimal independence with no need for additional support. DLA Administrators follow defined descriptions for each score level to ensure consistency in rating, and in cases of variability in performance, the lower score that reflects the more frequent pattern is recorded. After rating all items, a composite score is calculated by summing the individual item scores and dividing by the total number of items, provided that at least 15 of the 20 items are completed—ensuring the validity of the assessment.

Responsibility and requirements of trained, qualified practitioner

1. Administer the WHODAS 2.0 assessment tool using the WHO complex scoring spreadsheet, which automatically calculates the scores for each domain as well as an overall score.
2. Meet the requirements of a "trained, qualified practitioner" as defined by the state. North Dakota has defined a trained, qualified practitioner as: *An independent agent who has reviewed the 1915(i) WHODAS policy, and associated training on the administration and scoring of the WHODAS 2.0* located on the 1915(i) website and in the official WHODAS 2.0 Manual.

Responsibilities and requirements of the Human Service Zone Eligibility Workers include(s):

1. Prior to 1915(i) enrollment, the Zone Eligibility Workers are also responsible for Medicaid enrollment of the individual. The worker determining 1915(i) eligibility may,or may not be, the same Zone employee determining Medicaid eligibility for the individual. This process includes informing the applicant of their rights and responsibilities, which is verified by applicant's signature on the Medicaid form;
2. Enrolling individuals in 1915(i);
3. Verify proof of diagnosis; and proof of a needs-based assessment and score. To obtain the information that will be used in determining needs-based eligibility:
   a. the individual seeking eligibility may provide the Zone Eligibility Worker with proof of diagnosis and completed assessment using a 1915(i) Eligibility Determination Form. The form will be used to document the individual's diagnosis and name and signature of the diagnosing provider or verifying staff person. Documentation attached to the form containing this required information may replace the clinician or verifying staff person's signature on the form. The form willalso document the needs-based assessment, scoring information, and name of the administrator. The DLA or WHODAS 2.0 assessment and 1915(i) scoring sheet must accompany the form. A printout of the individual's Human Service Center Electronic Health Record containing the WHODAS scores, may be attached to the form as a substitute for the required 1915(i) score sheet and

assessment; or

b. Zone Eligibility Worker may assist the individual with obtaining proof of diagnosis from their diagnosing provider and proof of assessment score.

c. The Zone Eligibility worker may administer the WHODAS 2.0 if the individual does not have a WHODAS score from a trained, qualified practitioner.

4. Entering the needs-based eligibility information into a web-based system as proof of 1915(i) eligibility. The web-based system will be used to verify the information provided meets the needs-based eligibility requirements;

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4. ● **Reevaluation Schedule**. *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ● **Needs-based HCBS Eligibility Criteria.** *(By checking this box, the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The State has developed eligibility criteria in accordance with 42 CFR 441.715.

In addition to meeting the Target Group Eligibility Criteria, the participant must also meet the following Needs-Based HCBS eligibility criteria:

Assistance with activities of daily living and/or instrumental activities of daily living due to an impairment, as evidenced by one of the following:

1. *a complex score of 25 or higher on the WHODAS 2.0; or*
2. *A score of 5 or lower on the Daily Living Activities (DLA-20).*

6. ● **Needs-based Institutional and Waiver Criteria.** *(By checking this box, the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF LOC**	**ICF/IID LOC**	**Hospital LOC**
An impairment which substantially interferes with or substantially limits the ability to function in the family, school or community setting, as evidenced by a complex score of 25 or higher on the WHODAS 2.0, or a score of 5 or lower on the DLA.	The requirement of care that is medically necessary with significant and continual support for activities of daily living, requiring 24/7 monitoring and supervision.	The requirement of an intellectual/developmental disability and exhibits self-harm, harm to others, and inability to take care of basic daily needs, putting their physical safety at risk, requiring 24/7 monitoring and supervision.	A psychiatric condition that places the individual at extreme risk due to self-harm, harm to others, or severely neglecting basic hygiene or starving self that predicts death, requiring 24/7 monitoring and supervision. The minimum WHODAS 2.0 assessment score ranges between 96-100. Disability impairment only applies to psychiatric rehabilitative hospitalization. The minimum DLA assessment score ranges between 0-2. Disability impairment only applies to psychiatric rehabilitative hospitalization.

7. ● **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with1915(i)(7)(c) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

North Dakota targets all services by diagnosis in this 1915(i) benefit by diagnosis.Individuals must possess one or more qualifying diagnoses. Qualifying diagnoses include behavioral health conditions, substance abuse disorders, and brain injury. For respite care services, all individuals must also be between the ages of 0-20.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolledindividuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-inservices and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

N/A

(By checking the following box, the State assures that):

8. ● **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. Reasonable Indication of Need for Services. In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. The Care Coordinators are responsible for monthly monitoring of the 1915(i) services. Monthly monitoring does not need to happen in person. Specifythe state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:*	
	1	
ii.	**Frequency of services**. The state requires (select one):	
	☐	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency: **Quarterly**

Home and Community-Based Settings

(By checking the following box, the State assures that):

● **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community- based settings requirements, at the time of submission and in the future):*

The state provides services across multiple Human Community-Based (HCB) settings. Across all service settings, the state implements a uniform initial assessment and ongoing monitoring process to ensure consistency in quality and performance. Across all settings, the same standardized procedures are utilized. This process begins with an initial assessment done by the Care Coordinator while creating the plan of care, that identifies each participant's specific needs at the time of enrollment, followed by regular, consistent evaluations to monitor progress, updating the plan of care as needed, to ensure accountability. By maintaining similar protocols across all settings, the state promotes equitable care delivery, and continuous quality improvement.

Settings

Setting Type #1: Prevocational Service Centers
Services offered at this Setting Type: Peer Support, Housing Support, Supported Education, Supported Employment, Benefits Planning, Pre-Vocational Training

Setting Type #2: Participants Own/Family Homes
Services offered at this setting type: Peer Support, Family Peer Support, Housing Support, Supported Education, Supported Employment, Respite, Benefits Planning, Pre-Vocational Training, Training and Support for Unpaid Caregivers

Setting Type #3: Various locations in the community where participants wish to go:
Services offered at this setting type: Peer Support, Family Peer Support, Housing Support, Supported Education, Supported Employment, Respite, Benefits Planning, Pre-Vocational Training, Training and Support for Unpaid Caregivers, Non-Medical Transportation

Setting Type #4: Sober Living Homes, Group Homes, Foster Homes, Treatment Foster Homes, Transitional Living Homes:
Services Offered at this setting type: Peer Support, Family Peer Support, Housing Support, Supported Education, Supported Employment, Respite, Benefits Planning, Pre-Vocational Training, Training and Support for Unpaid Caregivers, Non-Medical Transportation

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Medical Services Division and contracted MCO will implement the following process to ensure compliance with the federal and state Home and Community-Based Settings requirements at 42 CFR 441.710(a)(1)-(2) and ensure all participants receiving HCBS have personal choice, and are integrated in and have full access to their communities, including opportunities to engage in community life, work and attend schoolin integrated environments, and control their own personal resources.

Medical Services Division and contracted MCO will communicate with the public, providers, Zones, and potential referral sources where HCBS services can be delivered and where they cannot.

The State Plan HCBS benefit will be furnished to those eligible individuals who receive HCBS in their own homes, in provider owned and controlled residential settings (Sober Living Homes, Group Homes, Foster Homes, Treatment Foster Homes, Transitional Living Homes), in non-residential settings, and in the community at large. For provider owned and controlled residential settings, the care coordinator will follow these steps to confirm HCBS compliance:

1. **Care Coordinator Evaluation:** Before the first service authorization, and at every POC review/update, the member's assigned care coordinator visits the proposed HCBS setting. During that visit, the care coordinator completes the HCBS Settings Assessment Guide found on the state's website, side-by-side with the member and provider, collects supporting details of the setting, and applies the results in the plan of care. During this process the care coordinator makes sure all the settings are fully compliant with all of the settings criteria, The plan of care cannot be finalized, and services at the non-compliant setting are not authorized until the care coordinator certifies that the setting is compliant with HCBS requirements. When a setting lacks institutional characteristics but fails one or more other HCBS Settings Rule criteria, the state triggers a targeted remediation process. The case manager issues a written notice identifying the specific deficiency and establishes a timeline for corrective action. In partnership with the provider, the case manager develops a Corrective Action Plan (CAP) with clear, measurable steps and assigns responsibilities. The state provides assistance, such as training to support implementation. Progress is monitored through site visits and documentation reviews, and the setting is re-evaluated against all relevant criteria upon CAP completion. If compliance is achieved, oversight returns to routine monitoring; if not, another CAP will be created to see if compliance is possible. If it is not, the state will work with the care coordinator to find alternative services for the member.

2. **Corrective Action:** Any Partial or Non-compliant item triggers a Corrective Action Plan applied through the HCBS Setting Requirements checklist. The care coordinator and provider develop a time-bound remediation schedule. The care coordinator monitors progress, and documents evidence of completion before authorizing or continuing services. Modifications to settings requirements are based on the individual's person-centered service plan and do not serve as a convenience to the provider or provider staff.

3. **Heightened Scrutiny Protocol (if needed)**: If the care coordinator believes the setting falls under any category of institutional presumption as outlined in the regulation, they complete the full HCBS Heightened Scrutiny Visit Form found on the state's website and compile all evidence. The completed Heightened Scrutiny Visit Form is forwarded to the 1915(i) Program Administrator**,** who, together with the care coordinator, determines whether the setting satisfies every HCBS Settings Criterion. No HCBS services are authorized or delivered at the setting until the joint determination between the 1915(i) care coordinator and 1915(i) program administrator confirms full compliance. If the setting is deemed non-compliant, the care coordinator initiates a corrective-action plan with the provider; services may begin only after successful remediation and follow-up review documents compliance. If the corrective action plan fails to achieve successful remediation, the state will prohibit 1915(i) services from being delivered at that location. The provider remains barred from resuming services at that location until it secures re-certification and the 1915(i) care coordinator and 1915(i) program administrator jointly verifies full compliance. An individual, person-centered review for each participant is conducted whenever provider non-compliance is identified. Whenever a provider fails remediation, the state requires the care coordinator to immediately explore alternative provider arrangements or interim support. The care coordinator will consult with the participant, and the 1915(i) Program Administrator to identify community resources that can temporarily or permanently assume services. These efforts, including outreach attempts, transition plans, and any service modifications, must be documented in the member's case notes and communicated to the member. This reinforces the state's commitment to minimizing service interruptions and upholding member rights during any provider non-compliance events.

4. **Ongoing Monitoring**: At every plan of care review (done at a minimum of every 90 days), the care coordinator completes the HCBS Settings Assessment Guide to verify continued compliance. Member complaints trigger an immediate assessment by the care coordinator. Any new

non-compliance results in a hold on new authorizations, and possible suspension of existing ones, until the care coordinator documents full remediation.

Individuals residing in institutions will not receive HCBS as federal and state regulations do not allow for this as the individual should receive all care determined necessary from the institution under other Medicaid authorities. However, the state will allow for an individual residing in an institution to undergo a "1915(i) pre-eligibility determination" within 90 days of the individual's identified discharge date in the event the institutional case manager provides the Zone EligibilityWorker with a qualifying diagnosis; WHODAS or DLA score; FPL of 150% or below; and a need for 1915(i) services has been identified for the individual. The Zone Eligibility Worker will complete a "pre-eligibility" screening and place the individual in "pending" status until the day following discharge from the institution when final eligibility can be determined.

Whenever possible, 1915(i) pre-eligibility should take place to allow for good discharge planning to occur and HCBS services to begin soon after discharge from the institution. Those individuals residing in an institution with discharge plans identifying a need for Community Transition Services will also undergo a pre-eligibility screening process as part of the 1915(i) Community Transition process.

Referral sources will not submit a 1915(i) referral/application for individuals residing in any of the state's institutions until the date of discharge is set and the individual's discharge plan developed by the institutional case manager identifies a qualifying diagnosis; WHODAS or DLA score; and Federal Poverty Level (FPL) of 150% or below, as well as a need for 1915(i) HCBS services.

The state will assure 1915(i) compliance with the setting requirements at 42 CFR441.710(a)(1)-(2).

Following the 1915(i)-eligibility determination, the individual's care coordinator is responsible for verifying initial and ongoing HCBS Settings compliance prior to their use.

Medical Services Division and contracted MCO will implement and follow HCBS Settings Rule Verification process to ensure compliance with current regulations.

SERVICE SETTINGS: Members should receive home and community-based services in their homes and communities. The service setting is where the service occurs. Except for Community Transition Services, the below requirements apply to all 1915(i) service settings. Home and community-based service setting requirements. All settings require the Person-Centered Planning Process Self-Assessment. The assessment is part of the plan of care development, and review process. This is done at the initiation of 1915(i) services, and at a minimum at each quarterly meeting as well. This assessment helps the care coordinator determine if the member's service setting is HCBS-compliant. The state or the MCO reviews all plans of care, when they are created, and at any point when they are updated.

- Integrated in and supports member access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Selected by the member from options identified based on the member's needs and preferences, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Right to privacy, dignity, and respect, and freedom from coercion and restraint
- Optimizes, but does not regiment member autonomy and independence in making life choices, not limited to daily activities, physical environment, and who the member interacts with
- Facilitates member choice regarding services and supports and who provides them.

Responsibilities to Ensure Initial & On-Going Compliance

1. Implement person-centered service planning practices and develop POCs according to regulations, which includes documentation of service settings compliance.
2. Assess and monitor the physical environment of the client's home and settings where 1915(i) services are provided.
3. Anytime the plan is for a 1915(i) individual to begin receiving 1915(i) funded services within their place of residence, then the care coordinator must verify the new setting is compliant with the HCBS Settings Rule using the appropriate compliance verification measures prior to serviceprovision in the residential setting beginning.
4. Monitor service satisfaction and service plan implementation.

5. Conduct heightened scrutiny reviews and onsite visits.
6. Verification of HCBS Settings Compliance must be documented in the plan of care.
7. Remediate non-compliance issues.

Ongoing Monitoring for Compliance:

In addition to the required initial HCBS Settings Rule verification which takes place immediately following the individual's eligibility determination and prior to service delivery, verification of settings must be continually assessed by the care coordinator through face-to-face visits and the person-centered planning and self-assessment process and ongoing compliance documented in the plan of care throughout the individual's eligibility. *Correction is required at any point settings non-compliance is identified.*

The HCBS Service Settings part of the Person-Centered Planning Process and POC development and review:

The POC template contains HCBS service setting questions to assist care coordinators in gathering and evaluating information regarding the member's service setting(s).

The questions are completed by the care coordinator in collaboration with the individual and address the following regulations 1-12 from Paragraphs (a)(1)(vi)(A) through of the Home and Community-Based Settings Federal Rule at 42 CFR 441.710. If modifications are required to any of the regulations to comply, then the *HCBS Settings Modifications section of the POC* must be completed as part of the required HCBS Settings Rule individual compliance verification measures:

1. People are living and regularly participating in integrated environments (e.g., using and interacting in the same environments by people without disabilities, regularly accessing the community, having the ability to come and go from the setting, access topublic transportation, etc.).
2. People have opportunities for employment and to work in competitive integrated settings (e.g., choice and opportunity to experience different work and/or day activities, support looking for a job if interested, meaningful non-work activities in thecommunity, etc.).
3. People have control and access of their money (e.g., able to buy needed items, use their own money when choosing to, accessibility of money, have their own bank account,etc.).
4. People have options and choices in where they live, work, and attend day services (including do they continue to be satisfied, choice in their own bedroom, and choice in whom they live with/share bedroom, etc.).
5. People experience privacy, dignity, and respect (e.g., have time alone, privacy during personal assistance, confidentiality of information, respectful staff interactions, being listened to and heard, ability to close/lock bathroom door, access to phone, etc.). In provider-owned or controlled residential settings, people are provided with the right to have lockable bedroom doors.
6. People have choice and control in daily life decisions, activities, and access to food(e.g., they understand their rights, they practice rights important to them, individualchoice/control in schedule and routines, availability of food, choice in when/what/where to have meals, etc.).
7. People have the freedom to furnish and decorate their room/home (e.g., choose decorations, arrange furniture, hang pictures, change things if want to, décor reflects personal interests and preferences, etc.).
8. People have access to all areas of the setting (e.g., kitchen, break room, laundry room,community room, etc.).
9. People have visitors of their choice at any time.
10. People exercise their right of freedom from coercion and restraint (e.g., give informed consent, know who to talk to if not happy, least restrictive methods utilized first, etc.).
11. People choose their services and supports (e.g., choice in providers, service options, opportunities for meaningful non-work activities, opportunity to update/change preferences,etc.).
12. People are involved in their own planning process to the extent desired (choice of meeting location, people to invite, desired level of participation, development of plan,etc.).

Below is an example of the section of the POC where verification of settings compliance is documented:

HCBS Setting Assessment Questions
Is the member receiving 1915(i) services in a provider-owned or controlled residential setting? ☐ Yes - requires completion of additional Provider-Owned or Controlled Setting-specific questions as detailed above. ☐ No
Living Environment
Do you live in a community-based setting (community-based settings meet ALL below criteria) 1) Integrated in and supports full access to your community 2) Selected by you and setting options must include non-disability specific settings. 3) Ensures your rights of privacy, dignity and respect, and freedom from coercion and restraint. 4) Optimizes your choice and independence in making life decisions 5) You choose services and supports and who provides them.: ☐ Yes ☐ No
Date Care Coordinator verified HCBS Settings Rule compliance:

Modifications to the HCBS Settings Rule

The following "HCBS Settings Modifications" section of the POC must be completed by the care coordinator in collaboration with the individual and agency if any modifications to the rule are required. The need for continued modifications will be reviewed ongoing and lifted based on a participant's Person-Centered Planning process and POC.

HCBS Settings Modifications* *This section must be completed if any modifications are required to regulations under Paragraphs (a)(1)(vi)(A) through (D) of the Home and Community-Based Settings Federal Rule at 42 CFR 441.710. These regulations are identified as Items 1 – 12 on the POC Attachment 1 – Self-Assessment. (HCBS 1)*
For which specific setting(s) are the modifications required?
For which HCBS settings rule requirement does the modification apply?
Identify the modification's correlation to the individual's specific assessed need.
Document the positive interventions and supports used prior to any modifications indicated in this Person-Centered POC.

Document less intrusive attempts to meet the need that were not successful.
Include a clear description of the condition, i.e., diagnosis or other, that is directly proportionate to the specific assessed need pertaining to the modification.
Indicate how data will be collected and reviewed to measure the ongoing effectiveness of the modification.
Indicate how often the need for continuing the modification will be re-assessed.
Has this modification been made with the informed consent of the individual? ☐ Yes ☐ No
Explain how the modification(s) meet expectations for safety, allow the individual to feel safe, and prevent harm to the individual?

Settings Rule Compliance Remediation

Medicaid reimbursement will not occur for 1915(i) services delivered before initial required settings compliance measures are completed. However, if for any reason settings non-compliance is discovered after the initial compliance verification, then the care coordinator will immediately initiate the appropriate settings verification process for that particular setting category.

If remediation of the setting is a possibility, then the care coordinator will initiate the steps outlined below. Any identified issues will be remediated by using the person-centered plan of care process.

1. **Identification and Assessment**
   - The care coordinator reviews the existing plan of care and case notes any deviations from the expected service delivery. This step involves gathering data from case notes, observations, and feedback from the individual and their family or support network.

2. **Collaborative Engagement**
   - The provider, the member receiving services, and any relevant team members (e.g., family members) attend a meeting or series of meetings. The goal here is to ensure that everyone has a clear understanding of the gaps, the expectations, and the impact on the individual's overall care.

3. **Revision of the POC**
   - Using the information gathered, the care team works together to update the plan of care, to fully address the member's needs and wants.
   - The updated plan of care will include detailed answers to the below questions addressing the following areas (Specific Corrective Actions, Timeline and Milestones, Clarification of Roles, Ongoing Dialogue and Reassessment):
     a. Does the member reside in a unit or specific physical place that can be owned, rented, or occupied under a legally enforceable agreement?
     b. Does the member have privacy in their sleeping unit?
     c. Does the member have the freedom and support to control their own schedules and activities?
     d. Can the member have visitors of their choosing at any time?
     e. Can the member physically access the setting?

- The setting Modifications (if needed) will address the following questions/points:
    a. List the specific settings where modifications to the members' environment are needed.
    b. How are the modifications going to address an identified need?
    c. Describe any positive interventions and supports used prior to implementation of these modifications.
    d. As applicable, describe any less intrusive attempts to modify the environment which were not successful.
    e. Describe the member's physical condition or diagnosis if one correlates to the assessed need which requires the modification.
    f. How will you collect, review, and measure data to determine the effectiveness of this modification?
    g. How will this modification allow the member to feel safe, and/or prevent harm to the member?
    h. Has this modification been made with the members' informed consent?

An advocacy organization, Medical Services Division, or the contracted MCO may be contacted for issues not able to be remediated.

The care coordinator will provide the individual assistance with finding other HCBS options in their community that fully comply with the rule. Individuals will be provided choices among alternative settings that meet the individual's needs, preferences, and HCBS setting requirements. The care coordinator and person-centered planning team will develop a transition plan to assist with relocation efforts.

If it is not possible to provide any 1915(i) services in a compliant setting, the client's 1915(i) eligibility will terminate.

1915(i) Other Service Provider Responsibilities

1. Develop and implement agency policies and procedures that are aligned with the HCBS Settings Rule.
2. Provide initial and ongoing education on the HCBS Settings Rule to their staff who are responsible for service delivery as necessary.
3. Collaborate with the care coordinator during site visits, heightened scrutiny processes, person-centered planning process, and complete required remediation as needed.

Medical Services Division and contracted MCO Responsibilities

1. Utilize the Quality Improvement Strategy process
2. Provide policy and educational materials for care coordinators.
3. Participate in the internal NDDHHS HCBS settings committee (Medical Services Division only).
4. Participate in the heightened scrutiny process.

Heightened Scrutiny Process

When a setting requires heightened scrutiny, the care coordinator will utilize the 1915(i) Heightened Scrutiny form to evaluate all regulations and identify any institutional characteristics. The Heighted Scrutiny form is completed onsite for each setting by the care coordinator using provider policy review, observation and discussion with individuals, guardians, and provider staff. The care coordinator will work with the provider to complete the Heightened Scrutiny form and identify any areas of noncompliance, remediation efforts, and timelines for completion.

Examples of settings that may have the effect of isolating beneficiaries are:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;
- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or,
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.
- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid-funded HCBS;
    - The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
    - The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.

Care coordinators will implement remediation efforts for any noncompliance identified, and the care coordinators will gather feedback from individuals/legal decision makers to confirm remediation and compliance. The feedback will be gathered from individuals/legal decision makers in person or over the phone. Once this process is complete, the information along with the information submitted in the evidence package will be reviewed by an internal NDDHHS HCBS settings committee. The committee will be comprised of a representative from the State's Aging Services Division, Developmental Disabilities Division, Medical Services Division, and the State Risk Manager. The committee will decide if the setting:

a) Has successfully refuted the presumptively and now fully complies;
b) With additional changes will fully comply; or
c) Does not/cannot meet HCB settings requirements.

If it is determined that the setting has provided enough evidence that they fully comply, the evidence package will be submitted for public comment for 30 days. After the public comment period, it will be submitted to CMS to see if they concur.

If a decision is made that the provider cannot meet the regulations, they will be issued a denial for that setting. The care coordinator will inform the individual that the setting is not an option for them to reside in and receive 1915(i) services and will offer to assist the individual with locating a setting that complies with the HCBS Settings Rule. If any relocation of clients is needed, the person-centered planning process will be followed.

See the Heightened Scrutiny FAQ section of this policy, or visit the CMS FAQ documents located in the CMS Home and Community Based Settings Toolkit for answers to specific questions relating to heightened scrutiny:
Home & Community Based Settings Requirements Compliance Toolkit | Medicaid

Person-Centered Planning & Service Delivery

(By checking the following boxes, the state assures that):

1. ● There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ● Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ● The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

- **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):* WHODAS administrators must meet the requirements of a "trained, qualified practitioner" as defined by the state. North Dakota has defined a trained, qualified practitioner as: An independent agent who has reviewed the 1915(i) WHODAS policy, and associated training on the administration and scoring of the WHODAS 2.0 located on the 1915(i) website and in the official WHODAS 2.0 Manual.
  DLA administrators must meet the requirements of a "trained, qualified practitioner" as defined by the state. North Dakota has defined a trained, qualified practitioner as: An independent agent and trained prepared professional of the North Dakota Human Service Centers with a bachelor's degree.

An individual's needs are assessed through the completion of the WHODAS 2.0 or DLA Assessment. Agents verifying the assessment and score must be independent and qualified as defined in #2. Qualifications of Individuals Performing Evaluation/Reevaluation under the Evaluation/Reevaluation Section of this application.

4. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Qualifications for those responsible for Development of Person-Centered POC:
The persons responsible for the development of the individualized, person-centered service POC must meet all the following criteria:

- be at least 18 years or age and employed with an enrolled Medicaid provider of the Care Coordination service, and possess Medical Services Division or contracted MCO-required competencies as identified within the Care Coordination service part of this application; and one of the following:
- must have a bachelor's degree.
- If the individual does not have a bachelor's degree, they will be allowed to enroll to provide 1915(i) if they have at least three years of supervised experience working with individuals with behavioral health conditions in a role with case management functions such as individual assessment, monitoring and follow-up activities.

An agency that meets all the following criteria can enroll with ND Medicaid to provide the 1915(i) Care Coordination service:
Have a North Dakota Medicaid provider agreement and attest to the following:

- individual practitioners meet the required qualifications; and,
- services will be provided within their scope of practice; and,
- individual practitioners will have the required competencies identified in the service scope; and,
- agency availability or an alternative resource available 24 hours a day, 7 days a week to clients in crisis; and,
- agency conducts training in accordance with state policies and procedures; and,
- agency adheres to all 1915(i) policies and procedures, including participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request; and,
- supervisors of care coordination staff have a minimum of:
    - must have a bachelor's degree.
    - If the individual does not have a bachelor's degree, they will be allowed to enroll to provide 1915(i) if they have at least three years of supervised experience working with individuals with behavioral health conditions in a role with case management functions such as individual assessment, monitoring and follow-up activities.

5. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Supporting the Participant in Development of Person-Centered POC

The Care Coordinator informs the participant and legal guardian if applicable of their involvement in the development of the Plan of Care, and their right to choose who can be involved in the plan development. The participant and their guardian if applicable are given the opportunity to choose the times and location of meeting, and the makeup of team membership. The participant receives a handout which lists each of the services provided under the 1915(i), and a copy of the Member Rights and Responsibilities document that explains what to expect to include how to acquire a fair hearing.

The Care Coordinator assists the participant and guardian and team, if applicable, with developing the Person-Centered POC. The POC verifies all the following requirements are met: The POC must confirm the initial 1915i eligibility evaluation was completed by the Human Service Zone according to the process required by the state. For reevaluations, the POC must indicate the participant's eligibility was reviewed at the Zone within 365 days of their previous eligibility review.

- The POC must document the participant receives services in a compliant community-based setting as specified in the State Plan Amendment and in accordance with 42 CRF 441.710(a)(1) and (2).
- The POC must document the participant had choice of services.
- The POC must document the participant had choice of providers.
- The POC must identify and address assessed needs of the participant.
- The POC must contain the participant's signature stating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints and reporting procedures.
- The POC must be developed in collaboration with the participant, (and parent/guardian and team, as applicable), with goals, desired outcomes and preferences chosen by the participant.
- The POC must identify services, as well as frequency, duration, and amount of services, based on the needs identified by the independent assessment, as well as choice of the participant, to assist the participant with meeting the goals and outcomes they have identified in the Plan of Care.
- The POC must identify risk factors and barriers with strategies to overcome them, including an individualized back-up/crisis plan.

- The POC must include signatures of the participant, care coordinator, meeting participants, providers, and all others responsible for plan implementation. The provider's written or electronic signature must be in accordance with 42 CFR §441.725(b).
- The POC must be provided to the participant, family if applicable, providers, and all members responsible for plan implementation and monitoring.
- All Initial and revised POCs are stored in the state system.

The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. The Care Coordinator is responsible for in-depth monitoring of the Plan of Care which includes meeting face to face with the participant at least every 90 days to review quality and satisfaction with services, and to assure services are delivered as required and remain appropriate for the individual. This in-depth monitoring by the Care Coordinator will also include a review of all provider's monthly progress updates. This monitoring will include review case notes and contact with the providers. The care coordinator is still required to meet with the member face-to-face once every 90 days, at a minimum.

Prior to each annual Plan of Care review, the Care Coordinator will review the participant rights information with the individual and guardian if applicable, which includes their right to choose among and between services, providers, and their right to appeal if they are denied the choice of services or provider.

6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Assisting Participants with selecting from among qualified providers of the 1915(i)services

The individuals have a choice of Care Coordination service providers. The Care Coordinator, in collaboration with the individual (and parent/guardian and team as applicable) creates the initial POC. As part of the person-centered planning process, the Care Coordinator informs the participant (and parent/guardian as applicable), verbally and in writing, about their right to choose from among any Medical Services Division authorized provider or, for MCO enrolled participants, the contracted MCO-authorized providers of the chosen service.

As a recommended service is identified, the Care Coordinator will provide the participant with a list of providers containing the names and contact information of available providers.

Participants may interview potential service providers and select the provider of each service on the POC. The POC signed by the participant (and parent/guardian as applicable) contains a statement assuring they had a choice of provider.

The Care Coordinator provides the member will a "Member Rights" document, which among other things, ensures the participant is aware of their option to change 1915(i) service providersat any time, including the option to change their Care Coordinator.

7. Process for Making Person-Centered Service Plan Subject to the Approval of the MedicaidAgency. (Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):

The Care Coordinator submits all Plans of Care containing all services to be authorized. Plans of care for traditional Medicaid members are submitted to State Medicaid Agency staff for approval. The contracted MCO reviews POCs for Medicaid Expansion members. The process for POC submission and review are the same for the initial POC and all revised POCs. The state reviews the MCO's Plans of Care.

8. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

●	Medicaid agency	☐	Operating agency	☐	Case manager
	Other (*specify):*				

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Care Coordination**
Service Definition (Scope)*:*	

Services that assist participants in gaining access to needed 1915(i) and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Care Coordination is a required component of the 1915(i)-community based behavioral health service system.

The care coordinator is responsible for the development of the plan of care and for the ongoing monitoring of the provision of services included in the participant's plan of care. The Care Coordinator ensures that the participant (and parent/guardian as applicable) voice, preferences, and needs are central to the Person-Centered POC development and implementation. A minimum of one face to face contact between the Care Coordinator and participant per quarter is required. The quarterly meeting is face to face, and the monthly monitoring can be virtual or face to face, if the member chooses to meet. If not, the care coordinator can follow up on service progress by contacting the service provider, and/or reviewing case notes.

A participant's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a participant's identified goals in the Person-Centered POC and document the participant's progress toward their goals.

The Care Coordinator is responsible for the facilitation and oversight of this process,including:
A. Comprehensive assessment and reassessment activities include:

- completion of assessments as needed;

- collecting, organizing and interpreting an individual's data and history, including the gathering of documentation and information from other sources such as family members, medical providers, social workers, and educators, etc., to form a complete assessment of the individual, initially and ongoing;
- promoting the individual's strengths, preferences and needs by addressing social determinants of health including five key domains (economic stability, education, health and health care, neighborhood and built environment, and social and communitycontext) and assessing overall safety and risk including suicide risk;
- conducting a crisis assessment and plan initially and ongoing;
- guiding the family engagement process by exploring and assessing the participants, and in the case of a minor, the family's strengths, preferences, and needs, including overall safety and risk, including suicide risk, initially and ongoing;
- Initial and ongoing verification of Community-Based Settings compliance.

All requirements contained in the Person-Centered POC Section, #4, *Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities***,** of this application are applicable to the Care Coordination Service.

B. Development of an individualized Person-Centered POC, including the Crisis Plan component, based on the information collected through the assessment
All requirements contained in the Person-Centered POC Section, 5- *Responsibility for Development of Person-Centered Service Plan*, 6- *Supporting the Participant in Development of Person-Centered Service Plan*, #7- *Informed Choice of Providers*, #8- *Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency* and #9- *Maintenance of Person-Centered Service Plan Forms* of this application apply to the Care Coordination Service.

C. Crisis Plan Development, Implementation, and Monitoring
The Care Coordination Agency has ultimate responsibility for the development, implementation, and monitoring of the crisis plan. The crisis plan is developed by the Care Coordinator in collaboration with the participant and the Person-Centered Plan of Care Team within the first week of initial contact with the member.

Within the initial 60 days of a member's enrollment, it is vital to address any crisis situations and the need for stabilization of the members engagement in care coordination promptly while working to find appropriate long-term services. This ensures the members' immediate needs are met and they feel supported during the transition period. These crisis situations consist of collaborating with healthcare providers, social workers, and other relevant professionals to arrange for crisis care services. By taking these steps, a care coordinator can provide immediate support to a member facing a crisis while simultaneously working to develop the POC, identify and arrange appropriate long-term services. This approach ensures the member's safety and well-being during the critical initial period of enrollment.

D. Referral, Collateral Contacts & Related Activities
Depending upon what other services the individual receives, this may include scheduling appointments for the individual and engaging in other ways of connecting them with needed services including, but not limited to:

- Support in the areas of health, housing, social, educational, employment and other programs and services needed to address needs and achieve outcomes in the POC;
- Support to engage in culturally relevant community services and supports; and,
- contacts with non-eligible individuals that are directly related to identifying the eligible

individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, and providing members of the individual's team with useful feedback.

E. Monitoring and follow-up activities

Are activities and contacts necessary to ensure the person-centered plan is implemented and adequately addresses the eligible individual's needs.These may be with the individual, family members, service providers, or other entities or

individuals and conducted as frequently as necessary to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's POC;
- services in the plan are adequate;
- changes in the needs or status of the individual are reflected in the POC;
- monitoring and follow-up activities include making necessary adjustments in the POC and service arrangements with providers;
- transition of the participant from 1915(i) services to State plan, or other community-based services, when indicated; and,
- ongoing compliance with the HCBS Settings Rule.

Agencies must have records available for Medical Services Division or contracted MCO review documenting that Care Coordinators have reviewed or completed the following:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or
- The Case Management Society of America standards of practice; and
- State-sponsored Care Coordination training.

Agencies must also have records available for Medical Services Division or contracted MCO review as verification that Care Coordinators have reviewed Medical Services Division or contracted MCO approved training materials and acknowledge they are competent in the following areas:

- Person-Centered Plan Development and Implementation; and
- HCBS Settings Rule.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State plan service questions related to sufficiency of services.
(Choose each that applies):

●	Categorically needy *(specify limits):*

There is a daily maximum of 8 hours (32 units) for this service, and a minimum of one face to face contact between the Care Coordinator and participant per quarter is required. Service authorizations requests for additional hours required to prevent imminent institutionalization, hospitalization, or out ofhome/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

It is anticipated, and expected, that 1915(i) participants involved in multiple systems, waivers, and State Plan services, etc., will receive continued specialized case management from each specific program they are enrolled in. Each of these systems offer case management in their areas of expertise and serve an essential role in the individual's care.

While the individual may receive specialized case management from several areas, the state will allow only one case manager to bill during the same time period nor bill for the same case management activity regardless of the time period during which that activity is provided.

Case management for individuals eligible through multiple Medicaid authorities, such as the ND DD/IDD waiver and the 1915(i) benefit, are coordinated through a care coordinator who helps develop a person-centered plan of care. Each system provides case management within its area of expertise, ensuring that individuals receive specialized support for their unique needs. The coordination process includes:

Collaboration among case managers from different programs to align services and avoid duplication of services.

Regular communication entails scheduled interdisciplinary meetings, real-time case updates, and standardized information sharing protocols among all involved entities, including the DD Case Manager and 1915(i) care coordinator, special education, behavioral health services, and other relevant groups. This rigorous communication supports timely case reviews and coordinated adjustments to each member's care plan.

Person-centered planning, is coordinated through joint planning sessions, where input from the individual and their support network is actively sought and integrated into the plan of care. This ensures planning is comprehensive and responsive to the individual's evolving needs and wants.

Prevention of Service Duplication: The MMIS system shows all services the member is receiving and can be accessed on a continuous basis for on going monitoring for any new services the member my enroll in. The state has included edits in its MMIS system to prevent duplication of care coordination services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the individual through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the individual's record and kept on file.

Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders,verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:

- Telephone
- Secure Video Conferencing

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the individual into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriateuse of telehealth include:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing thechances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.
- Members amid a crisis or addiction relapse will be able tomore easily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.

●	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Care Coordination Services Medical Services Division defines billing group provider as an individual or entity that can enrollto provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency.	None	None	A provider of this service must meet all the following: • Have a North Dakota Medicaid provider agreement and attest to the following: o individual practitioners meet the required qualifications o services will be provided within their scope of practice o individual practitioners will have the required competencies identified in the service scope o agency availability, or a back-up resource available 24 hours a day, 7 days a week to clients in crisis o agency conducts training in accordance with state policies and procedures o agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and

Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			available for Medical Services Division review upon request.
Individual			The individual providing the service must: 1) be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and 1) 2) Be at least 18 years of age 3) Must have a bachelor's degree. 4) If the individual does not have a bachelor's degree, they will be allowed to enroll to provide 1915(i) if they have at least three years of supervised experience working with individuals with behavioral health conditions in a

			role with case management functions such as individual assessment, care plan development and maintenance, referral and appointment scheduling, monitoring and follow-up activities.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

North Dakota Medicaid enrolled agency provider of Care Coordination Services	Medical Services Provider Enrollment	Provider will complete an "Attestation" as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	●	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Training and Support for Unpaid Caregivers**

Service Definition (Scope)*:*

Training and Support for Unpaid Caregivers is a service directed to individuals providing unpaid support to a recipient of 1915(i) services. Services are provided for the purpose of preserving, educating, and supporting the family and support system of the participant.

For purposes of this service, individual is defined as any person, including but not limited to, a parent, relative, foster parent, grandparent, legal guardian, adoptive parent, neighbor, spouse, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a 1915(i) participant.

A participant's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a participant's identified goals in the Person-Centered POC and document the participant's progress toward their goals.

Covered activities may include the following:

1) practical living and decision-making skills;
2) child development, parenting skills, and assistance with family reunification including the provision of role modeling or appropriate parenting and family skills for parents and children during visitations; and facilitating engagement and active participation of the family in the planning process and with the ongoing instruction and reinforcement of skills learned throughout the recovery process;
3) home management skills including budget planning, money management, and related skills that will maximize a family's financial resources; guidance in proper nutrition through meal planning, planned grocery purchasing, and identification of alternative food sources;
4) provide information, instruction, and guidance in performing household tasks, personal care tasks, and related basic hygiene tasks;
5) use of community resources and development of informal supports;
6) conflict resolution;
7) coping skills;

8) gaining an understanding of the member's behavioral health needs, including medications (purpose and side effects), mental illness or substance use disorder symptomology, and implementation of behavior plans; 9) learning communication and crisis de-escalation skills geared for working with the member's behavioral health needs; 10) training or education on a patient suicide safety plan and counseling on lethal means; 11) systems mediation and advocacy; and, 12) assist with accessing services, transportation arrangements, and coordination ofservices and appointments. Agencies must have records available for Medical Services Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following: o Person-Centered Plan Implementation
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State plan service questions related to sufficiency of services. *(Choose each that applies):*

x	Categorically needy *(specify limits):*

This service is billed using a 15-minute unit or reimbursement of cost of training.

The maximum daily limit for the service is eight (8) hours (32 units). Service authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

This service is not available to caregivers who are paid to care for the participant.

Reimbursement is not available for the costs of travel, meals, or overnight lodging.

Training purchases will be procured through a third-party fiscal agent. Items, vendor, and cost must be identified in the Person-Centered POC. The third-party fiscal agent is unable to reimburse the participant or anyone other than the vendor.

See the current fee schedule for the maximum allowabletraining budget per year.

Requests for training budget costs beyond the service limit which are necessary to prevent imminent institutionalization, hospitalization, or out of community placement must be included on the POC and submitted for service authorization to the Medical Services Division or contracted MCO. This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs a service which is offered in both, the individual member is required to access the service through the 1915(c) rather than the 1915(i).

At this time the state has identified no duplication between this service offered in the 1915(i) and any services offered in the state's HCBS 1915(c) Waivers.

If the HCBS 1915(c) Waivers were to offer a similar service in the future, the state will implement the following approach to ensure that 1915(i) services are not duplicated:

- The Care Coordinator will look at MMIS to determine if the participant is covered under a 1915(c) Waiver authority. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the individual through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

	Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month. Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders,verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises. Telehealth options include: • Telephone • Secure Video Conferencing For each utilization, providers must document that the telehealth option: • was elected by the member receiving services; • did not block the member's access to the community; • did not prohibit needed in-person services for the member; • utilized a HIPAA-compliant platform; and • prioritized the integration of the member into the community. The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate use of telehealth include: • Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing thechances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept. • Members amid a crisis or addiction relapse will be able tomore easily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.
x	Medically needy *(specify limits):*
	Same limits as those for categorically needy.
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Training and Supports for Unpaid Caregivers. (RATE #1) Medical Services Division defines billing group provider as an individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency.	None	None	A provider of this service must meet all the following criteria: Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request

Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individual	None	Have a minimum of two years of experience working with or caring for individuals in the Target Population; or be certified as a Parent Aide, Mental Health Technician, Behavioral Health Technician, Healthy Families Home	The individual providing the service must: 1) Be employed by an enrolled ND Medicaid provider of this service, and 2) Be at least 18 years of age and possesses a high school diploma, or equivalent, and 3) Have a minimum of two years of experience working with or caring for individuals in the Target Population; or be certified as a Parent Aide, Mental Health Technician, Behavioral Health Technician, Healthy Families Home Visitor, Parents as Teachers Home Visitor, Nurse Family Partnerships Program Visitor, or other Medical

		Visitor, Parents as Teachers Home Visitor,	Services Division approved certification.

		Nurse Family Partnerships Program Visitor, or other Medical Services Division approved certification.	Supervisors of staff providing this service must meet the requirements of an individual providing services and have two or more years of experience in providing direct support to caregivers.
North Dakota Medicaid enrolled agency provider of Individual Training Budget Purchases (RATE #2) VERIDIAN	None	None	A provider of this service must have a North Dakota Medicaid provider agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agency provider of Training and Supports for Unpaid Caregivers Rate #1 Component	North Dakota Medical Services Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.
Individual Training Budget Purchases Rate #2 Component	North Dakota Medical Services Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least

		once every five (5) years.

Service Delivery Method. *(Check each that applies)*:		
Participant-directed	x	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Peer Support**
Service Definition (Scope)*:*	

Services are delivered to members age 18 and older by trained and certified individuals in mental health or substance use recovery that promote hope, self-determination, and skills to achieve long- term recovery in the community. Peer Support Specialists have lived experience as a recipient of behavioral health services with a willingness to share personal, practical experience, knowledge, andfirst-hand insight to benefit service users. Services are provided in a variety of home and communitybased (HCBS) settings including: the individual's home, a community mental health center, a peer recovery center and other community settings where an individual and a peer may meet and interact i.e., community center, park, grocery store, etc.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and documentthe member's progress toward their goals.

Peer Support Specialists require knowledge and skill in Person-Centered Plan Implementation.

Community-based peer support, including forensic peer support - Trauma-informed, non-clinical assistance to achieve long-term recovery from a behavioral health disorder. Activities included mustbe intended to achieve the identified goals or objectives as set forth in the person-centeredplan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilizecommunity and natural supports. The intent of these activities is to assist members in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

Peer Support services include:

1) Engagement, bridging,
   providing engagement and support to a member following their transition from an institutional setting (state hospital, inpatient hospital, congregate care, nursing facility, or correctional settings) to their home communities
2) Coaching and enhancing a recovery-oriented attitude:
   - Promoting wellness through modeling.
   - Assisting with understanding the person-centered planning meeting.
   - Coaching the member to articulate recovery goals.
   - Providing mutual support, hope, reassurance, and advocacy that include sharing one's own "personal recovery/resiliency story"
3) Self-Advocacy, self-efficacy, and empowerment

- Sharing stories of recovery and/or advocacy involvement for the purpose of assisting recovery and self-advocacy;
- Serving as an advocate, mentor, or facilitator for resolution of issues
- Assisting in navigating the service system including
- Helping develop self-advocacy skills (e.g., assistance with shared decisionmaking, developing mental health advanced directives).
- Assisting the member with gaining and regaining the ability to make independent choices and assist members in playing a proactive role in their own treatment (assisting/mentoring them in discussing questions or concerns about medications, diagnoses or treatment approaches with their treating clinician). The Peer Specialist guides the member to effectively communicate their individual preferences to providers.
- Assisting with developing skills to advocate for needed services and benefits and seeking to effectively resolve unmet needs.
- Advocacy and coaching on reasonable accommodations as defined by Americanswith Disabilities Act (ADA)

4) Skill development
   - Developing skills for coping with and managing psychiatric symptoms, trauma, and substance use disorders;
   - Developing skills for wellness, resiliency and recovery support;
   - Developing, implementing and providing health and wellness training to address preventable risk factors for medical conditions.
   - Developing skills to independently navigate the service system; promoting the integration of physical and mental health care;
   - Developing goal-setting skills;
   - Building community living skills.
5) Community Connections and Natural Support are provided by peers and completed in partnership with members for the specific purpose of achieving increased communityinclusion and participation, independence and productivity.
   - Connecting members to community resources and services.
   - Accompanying members to appointments and meetings for the purpose of mentoring and support.
   - Helping develop a network for information and support, including connecting members with cultural/ spiritual activities, locating groups/programs based on a member's interest including peer-run programs, and support groups.
6) Peer Relief Services are voluntary short-term and offer interventions to support members for adverting a psychiatric crisis. The premise behind peer relief is that psychiatric emergency services can be avoided if less intrusive supports are available in the community.

	Additional needs-based criteria for receiving the service, if applicable *(specify):*
	Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, durationand scope than those services available to a medically needy recipient, and services must be equalfor any member within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*
x	Categorically needy *(specify limits):*
	Peer support services are billed in 15-minutes units. Services are limited to eight (8) hours

per day (32 units daily). Service authorizations requests for additional hours required to prevent imminent institutionalization, hospitalization, or out ofhome/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

Service is limited to members age 18 and older.

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i).

At this time the state has identified no duplication between this service offered in the 1915(i) and any services offered in the state's HCBS 1915(c) Waivers. If the HCBS 1915(c) Waivers were to offer a similar service in the future, the state will implement the following approach to ensure that 1915(i) services are not duplicated:

- The Care Coordinator will look up the member in MMIS to see if they are eligible for a C Waiver. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

State plan 1915(i) HCBS will not be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities.

Peer Support Specialist delivering services through telehealth must meet in-person with the member before providing the telehealth services, and then maintain at minimum a quarterly in-person visit. In-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services.

Telehealth options include:

- Telephone
- Secure Video Conferencing

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Examples of the appropriate useof telehealth include:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.
- Members amid a crisis or addiction relapse will be able to more easily reach out to 1915(i) service providers, reducing risks associated withtheir conditions and the likelihood of needing a higher level of care.

Agencies must have records available for Medical Services Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

Medically needy *(specify limits):*

Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
North Dakota Medicaid Enrolled Agency Provider of – Peer Support Medical Services Division defines	None	None	An enrolled agency provider of this service mustmeet all the following criteria to enroll as a provider: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the

billing group provider as an individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency. Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a			required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written andavailable for Medical Services Division review upon request.

provider is not an OLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each billing group provider mustmeet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			

Individual		Peer Support Specialist certified under NDAC 75-03-43	The individual providing the service must:
			1. Be employed by a ND Medicaid enrolled agency provider of this service.
			2. Be at least 18 years of age.
			3. Be certified as a Peer Support Specialist I or II under NDAC 75-03-43
			4. Maintain current certification as a Peer Support Specialist I or II as required by NDAC 75-03-43-06 Recertification and 75-03-43-07
			
			Supervision Requirements:
			For every 30 hours of Peer Support services provided, the individual provider must have one hour of face-to-face supervision with a qualified Peer Supervisor. The provider agency employing the peer specialist and supervisor is required to document the following requirements and have the documentation accessible for review by the Medical Services Division.
			
			A Qualified Peer Supervisor must:
			• Be at least 18 years of age
			• Be a certified peer specialist II; OR
			  • Have one of the following combinations:
			  ▪ High school diploma orGED and at least:

			• Be a North Dakota certified Peer Support Specialist I • Three years of work experience as a peer specialist or peer recovery coach including at least 2,250 hours of direct client service; or • Two years of work experience as a peer specialist or peer recovery coach including at least 1,500 hours of direct clientservice, and at least one year of full- time work experience supervising others; or • Associate degree from an accredited college or university and at least two years of work experience as a peer specialist or peer recovery coach including at least 1500 hours of direct client service; or • Bachelor's degree from an accredited college or university and at least two years of full-time work experience supervising others; or • Be the director of an organization providing peer support services; and • Have completed a state-approved peer support specialist supervision training.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

North Dakota enrolled agency provider of Peer Support	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part ofthe provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Family Peer Support**

Service Definition (Scope)*:*

Family Peer Support Services (FPSS) are delivered to families caring for a 1915(i) participant, under the age of 18, by trained and certified Peer Support Specialists with lived experience as a parent or primary caregiver who has navigated child serving systems on behalf of their child(ren)with social, emotional, developmental, health and/or behavioral healthcare needs. FPSS provide a structured, strength-based relationship between a Family Peer Support provider and the parent/family member/caregiver for the benefit of the child/youth. Services are delivered in a trauma informed, culturally responsive, person-centered, recovery-oriented manner.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a participant's identified goals in the Person-Centered POC and document the participant's progress toward their goals.

Family is defined as the primary care-giving unit and is inclusive of a wide diversity of primary caregiving units with significant attachment to the child, including but not limited to, birth, foster, adoptive, or guardianships, even if the child is living outside of the home.

Services can be provided in any compliant community-based setting with the participant's primary care-giver present.

Peer Support Services Include:
Engagement and Bridging,

- Serving as a bridge between families and service providers, supporting a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
- Based on the strengths and needs of the youth and family, connecting them with appropriate services and supports. Accompanying the family when visiting programs.
- Facilitating meetings between families and service providers.
- Assisting the family to gather, organize and prepare documents needed for specific services.
- Addressing any concrete or subjective barriers that may prevent full participation in services,

- Supporting and assisting families during stages of transition which may be unfamiliar(e.g., placements, in crisis, and between service systems etc.).
- Promoting continuity of engagement and supports as families' needs and services change.

Self-Advocacy, Self-Efficacy, and Empowerment

- Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
- Supporting families to advocate on behalf of themselves to promote shared decision-making.
- Ensuring that family members inform all planning and decision-making.
- Modeling strengths-based interactions by accentuating the positive.
- Supporting the families in discovering their strengths and concerns.
- Assist families to identify and set goals and short-term objectives.
- Preparing families for meetings and accompany them when needed.
- Empowering families to express their fears, expectations, and anxieties to promote positive effective communication.
- Assisting families to frame questions to ask providers.
- Providing opportunities for families to connect to and support one another.
- Supporting and encouraging family participation in community, regional, state, national activities to develop their leadership skills and expand their circles of support.
- Providing leadership opportunities for families who are receiving Family Peer Support Services.
- Empowering families to make informed decisions regarding the nature of supports for themselves and their child through:
    - Sharing information about resources, services, and supports and exploring what might be appropriate for their child and family.
    - Exploring the needs and preferences of the family and locating relevant resources.
    - Helping families understand eligibility rules.
    - Helping families understand the assessment process and identify their child's strengths, needs, and diagnosis.

Parent Skill Development

- Supporting the efforts of families in caring for and strengthening the health, development, and well-being of their children.
- Helping the family learn and practice strategies to support their child's positive behavior.
- Assisting the family to implement strategies recommended by clinicians.
- Assisting families in talking with clinicians about their comfort with their treatment plans.
- Providing emotional support for the family on their parenting journey to reduce isolation, feelings of stigma, blame and hopelessness.
- Providing individual or group parent skill development related to the needs of the child (i.e., training on special needs parenting skills).
- Supporting families as children transition from out of home placement.
- Assisting families on how to access transportation.
- Supporting the parent in their role as their child's educational advocate by providing information, modeling, coaching in how to build effective partnerships, and exploring educational options with families and school staff.

Community Connections and Natural Supports

- Enhancing the quality of life by integration and supports for families in their own communities.
- Helping the family to rediscover and reconnect to natural supports already present in their lives.
- Utilizing the families' knowledge of their community in developing new supportive relationships.
- Helping the family identify and become involved in leisure and recreational activities in their community.
- In partnership with community leaders, encouraging families who express an interest to become more involved in faith or cultural organizations.
- Arranging support and training as needed to facilitate participation in community activities.
- Conducting groups with families to strengthen social skills, decrease isolation, provide emotional support, and create opportunities for ongoing natural support.
- Working collaboratively with schools to promote family engagement.

Agencies must have records available for Medical Services Division review documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State plan service questions related to sufficiency of services.

(Choose each that applies):

- ● Categorically needy *(specify limits):*

Family Peer support services are billed in 15-minutes units. Services are limited to eight (8) hours per day (32 units daily). Service Authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

Services is limited to families with participants under the age of 18.

The following activities are not reimbursable for family peer support programs:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g., during a day treatment program) except for attending school meetings with the parent/caregiver on behalf of thechild.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's plan of care.

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternateauthority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i)and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i).

At this time the state has identified no duplication between this service offered in the 1915(i) and any services offered in the state's HCBS 1915(c) Waivers.

If the HCBS 1915(c) Waivers were to offer a similar service in the future, the state will implement the following approach to ensure that 1915(i) services are not duplicated:

- The Care Coordinator will look in MMIS to see if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

Family Peer Support Specialist delivering services through telehealth must meet in person with the participant before providing the telehealth services and maintain at minimum a quarterly in-person visit. In-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:

- Telephone
- Secure Video Conferencing

Telehealth must:

- be elected by the member receiving services;
- not block the member's access to the community;
- not prohibit needed in-person services for the member;
- utilize a HIPPA compliant platform; and
- prioritize the integration of the member into the community.

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring

members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate useof telehealth include:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from
  others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chancesthey will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.
- Members amid a crisis or addiction relapse will be able to more

	easily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care. Agencies must have records available for Medical Services Division review documenting that individual providers have knowledge of and competency in the following: • Person-Centered Plan Implementation
x	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*	Certification n *(Specify)*	Other Standard *(Specify):*
North Dakota Medicaid Enrolled Agency provider of Family Peer Support Medical Services Division defines billing group provider as an individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency.	None	None	An enrolled agency provider of this service must meet all the following criteria to enroll as a provider: Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) policies and procedures, includingbut not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request.

Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing			

group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individual		Peer Support Specialist certified under NDAC 75-03-43	The individual providing the service must: • Be employed by a ND Medicaid enrolled provider of this service. • Be at least 18 years of age • Be certified as a Peer Support Specialist I or II under NDAC 75-03-43. • Maintain current certification as a Peer Support Specialist I or II as required by NDAC 75-03-43-06 Recertification and 75-03-43-07 **Supervision Requirements:** For every 30 hours of Family Peer Support services provided,the individual provider must have one hour of face- to-face supervision with a qualified Peer Supervisor. The provider agency employing the peer specialist and supervisor is required to document the following requirements and have the documentation accessible for review by the Medical Services Division. A Qualified Peer Supervisor must: • Be at least 18 years of age; • Be a certified peer specialist II; or

			• Have one of the following combinations: ▪ High school diploma or GEDand at least: • Be a North Dakota Certified Peer Support Specialist I • Three years of work experience as a peer specialist or peer recovery coach including at least 2,250 hours of direct client service; or • Two years of work experience as a peer specialist or peer recovery coach including at least 1,500 hours of direct client service, and at least one year of full- time work experience supervising others; or • Associate degree from an accredited college or university and at least two yearsof work experience as a peer specialist or peer recovery coach including at least 1,500 hours of direct client service; or • Bachelor's degree from an accredited college or university and at least two years of full-time work experience supervising others; or • Be the director of an organization providing peer support services; and • Have completed a state approved peer support specialist supervision training

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota enrolled agency provider of Family Peer Support	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:			
o	Participant-directed	●	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Respite Care**

Service Definition (Scope)*:*

Respite care is targeted to individuals ages 0 to 20. Respite Care is a service provided to a member unable to care for themselves. The service is furnished on a short-term basis to provide needed relief to, or because of the absence of, the caregiver, including but not limited to the biological, kin, pre-adoptive, adoptive, and foster parent; and legal guardian.

Respite Care are available to members receiving the HCBS benefit who are residing in their family home (biological or kin), legal guardian's home, pre-adoptive/adoptive, or foster home.

Routine respite care may include hourly, daily, and overnight support.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and document the member's progress toward their goals.

Agencies must have records available for Medical Services Division documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

Persons and agencies providing respite care must comply with all state and federal respite standards. Approved 1915(i) service providers may also include:

- A relative related by blood, marriage, or adoption, who is not the legal guardian, does not live in the home with the member, and meets the standards and qualifications of an individual service provider.

Respite Care may be provided in the member's home/private place of residence, foster home, the private residence of the respite care provider, or any respite program located in an approved community-based setting and licensed by Medical Services Division.

Respite Care service activities include:

- Incidental assistance with daily living skills
- Assistance with accessing/transporting to/from community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving and cleanup
- Administration of medications
- Supervision
- Recreational and leisure activities, some examples are community outings, arts and crafts, sports and physical activities, outdoor recreation, social gatherings. The provision of these activities are to the extent of the same activities typically expected to be provided by a caregiver.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and servicesmust be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits):*

This service is reimbursed as a 15-minute unit rate. Maximum number of hours a memberis eligible is 40 hours per month (160 units per month) with a maximum of 480 hours per year. Service Authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO. The service will not go beyond 30 consecutive days when additional hours through the exception process are approved.

Respite care does not include on-going day care or before or after school programs. Respite care is not available to individuals residing in institutions including but not limited to Qualified Residential Treatment Provider facilities (QRTP) and Psychiatric Residential Treatment Centers (PRTF).
Respite is only available to primary caregivers in family settings. Payments will not be made for the routine care and supervision which would be expected to be provided by a family for activities or supervision for which a payment is made by a source other than Medicaid. Respite care shall not be used as day/child-care to allow the persons normally providing care to go to work or school. Respite care cannot be used to provide service to a participant while the participant is eligible to receive Individuals with Disabilities Education Act Part B services.

This service cannot be provided by individuals living in the home.

Individuals receiving Respite or In-Home Supports through a HCBS 1915(c) Authority Medically Fragile, Autism, Children's Hospice, ID/DD or Aged/Disabled Waiver are not eligible toreceive respite care through the 1915(i).

Receipt of respite care does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive supported employment on the same day as they receive respite care. Payment may not be made for respite furnished at the same time when other services that include care and supervision are provided.

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). The state has identified the Respite service, age 0 to 20, within the 1915(i) is duplicative of the Respite/In-Home Supports services within the following HCBS 1915(c) Waivers: ID/DD Waiver Medically Fragile Waiver; Autism Waiver; Children's Hospice Waiver; HCBS Age/Disable Waiver.

- The state will implement the following approach to ensure that 1915(i) services are not duplicative with other Medicaid-funded services: The Care Coordinator will look up the member in MMIS to see if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

This service is available to members ages 0 to 20.

Respite care do not include on-going day care or before or after school programs.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished.

☒	Medically needy *(specify limits):*
	Same limits as those for categorically needy.
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Respite Medical Services Division defines billing group provider as an individual or entity that is able to enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency.	Licensed Child Placing Agencies licensed under 75-03-36; Supervised Independent Living Programs licensed under NDAC 75-03-41;	None	A provider of this service must meet all the following criteria: Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures arewritten and available for Medical Services Division reviewupon request.
Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is	Child Care Centers licensed under NDAC 75-03-10; Providers licensed by theNDDHHS, Division of Developmental		

within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the providers are listed under each service.	Disabilities under NDAC 75-04-01; Qualified Residential Treatment Program Providers licensed by theNDDHHS, Children and Family Services Division, under 75-03-40 and enrolled as a 1915i Medicaid Provider; Psychiatric Residential Treatment Facility Providers licensed by the NDHHS Behavioral Health Division, under NDAC 75-03-17 and enrolled as a 1915(i) Medicaid Provider; Providers licensed by the NDHHS under 75-05-00.1 Human Service Center Licensure Substance Abuse Treatment Program licensed under NDAC 75-09.1		

Individual			The individual providing the service must: 1) Be employed by an enrolled ND Medicaid provider of this service. 2) Be at least 18 years of age 3) Be knowledgeable and competent in person-centered plan implementation

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agency provider of respite.	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate theirenrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Non-Medical Transportation (NMT)**

Service Definition (Scope):

This service is offered to enable 1915(i) members to gain access to 1915(i) and othercommunity services, activities, and resources, as specified by the person-centered plan of care. NMT increases the member's mobility in the community and supports inclusion and independence. This service is offered in addition to medical transportation and transportation services under the state plan and does not replace them. The service must be provided in the most appropriate, cost-effective mode available. Whenever possible, family, neighbors, friends,or community agencies which can provide this service without charge are utilized.

NMT services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State plan. NMT cannot be used for transporting a client to medical care; e.g., doctor, etc. NMT will be provided to meet the member's needs as determined by an assessment. Services are available for members to access authorized HCBS and destinations that are related to a goal included on the member's person-centered plan of care. Examples where this service may be requested include transportation to 1915(i) services, a job interview, college fair, a wellness seminar, a GED preparatory class, etc.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and document the member's progress toward their goals.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State plan service questions related to sufficiency of services.

(Choose each that applies):

●	Categorically needy *(specify limits):*
	NMT will only be available for non-routine, time-limited services, not for ongoing treatmentor services or for routine transportation to and from a job or school. All other options for transportation, such as informal supports, community services, and public transportation must be explored and utilized prior to requesting waiver transportation.This service is not intended to replace other transportation services but compliment them. A NMT provider must be enrolled in the ND Medicaid program and meet all applicable motor vehicle and licensing requirements.

	NMT is solely for transporting the member to and from their home to essential services as allowed within the scope of the service. It does not include the cost of staff transportation toor from the member's home. Individuals receiving Non-Medical Transportation services through the ND HCBS 1915(c)authorities including the Medically Fragile Waiver, and HCBS Aged/Disabled Waivers are not eligible to receive Non-Medical Transportation through the 1915(i). This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternateauthority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i)and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). The state has identified the Non-Medical Transportation service, age 0+, within the 1915(i) is duplicative of the following services within the HCBS 1915(c) Waivers: Medically Fragile Waiver; HCBS Aged/Disable Waiver. The state will implement the following approach to ensure that 1915(i) servicesare not duplicative with other Medicaid-funded services: The Care Coordinator will look at MMIS to see if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the planof care does not include duplicative services. Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Departmentof Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in themember's record and kept on file. Agencies must have records available for Medical Services Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following: o Person-Centered Plan Implementation
x	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Medicaid Enrolled agency provider of Non- Medical Transportation Provider Medical Services Division defines billing group provider as an individual orentity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitionersare allowed to enroll independently without being affiliated to a clinic, hospital or other agency. ,	NDCC Title 39-06 Motor Vehicles and Operating License	None	A provider of this service must meet all the following criteria: A group non-medical transportation provider must meet all the following: 1) Have a North Dakota Medicaid provider agreement and attest to the following: a) Agency adheres to ND State Laws regarding motor vehicles, operating licenses, registration, insurance, and uses licensed public transportation carriers NDCC Title 39-06 Motor Vehicles and Operating License, and b) Have a valid vehicle registration and current auto insurance if utilizing a company vehicle. The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service. 2) Be at least 18 years of age 3) Have a valid government issued driver's license

Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners			

are allowed to enroll as their own billing group provider if they choose. If a provider is not anOLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state planpages. The minimum qualifications for the provider are listed under each service.			

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Enrolled Medicaid agency provider of Non- Medical Transportation	North Dakota Medical Services Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	●	Provider managed

Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the stateplans to cover):*	
Service Title:	**Community Transition Services (CTS)**

Service Definition (Scope):

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a Medicaid-funded institution or another provider-operated/controlled *to* a living arrangement in a private residence where the person is directly responsible for their own living expenses.

The case manager responsible for coordinating the individual's discharge planning must request and receive approval for the service from the Medical Services Division or contracted MCO. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the plan development process, clearly identified in the plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. The state's Community Transition Service policy and procedures must be followed.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense requiredto occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. 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 person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Items purchased via this service are the property of the individual. Community Transition

Services are furnished, as follows:

- Community Transitions Services are time-limited and non-reoccurring set-up expenses and may be authorized up to 90 consecutive days prior to admission to the 1915(i) of an institutionalized person and 90 days from the date the client became eligible for the 1915(i).

- When 1915(i) Community Transition Services are furnished to individuals returning to the community from an institutional setting. The costs of such services are incurred and billable when the person leaves the institutional setting and enters 1915(i). The individual must be reasonably expected to be eligible for and to enroll in 1915(i) within 90 days of the initiation of 1915(i) services. If for any unseen reason, the individual does not enroll in the 1915(i) (e.g., due to death or a significant change in condition), costs may be billed to Medicaid as an administrative cost.

- All purchases will be procured through a third-party fiscal agent.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State plan service questions related to sufficiency of services.

(Choose each that applies):

● Categorically needy *(specify limits):*

	See the current fee schedule for the maximum allowable budgetper lifetime to be utilized within the 180 consecutive day window. This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). The state has identified the Community Transition service within the 1915(i) is duplicative of the following services within the HCBS 1915(c) Waivers: ID/DD Waiver; HCBS Aged/Disabled Waiver. Members currently or previously receiving Community Transition Services through the HCBS Aging/Disabled or DD Waivers are not eligible to receive Community Transition Services through the 1915(i). The state will implement the following approach to ensure that 1915(i) services are not duplicative with other Medicaid-funded services: The case manager requesting the Community Transition funding will review MMIS to see if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Medical Services Division will determine if the member has accessed Community Transition Services in the past and will not approve the request if prior access is confirmed. Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services arenot otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.
	○
X	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
ND Medicaid enrolled agency provider of Community Transition Services	None	None	A provider of this service must have a North Dakota Medicaid provider agreement.: The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service. 2) Be at least 18 years of age.

Medical Services Division defines billing group provider as an individual or entity that is able to enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency.			

Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each			

billing group provider must meet the qualifications specified in the 1915(i) stateplan pages. The minimum qualifications for the provider are listed under each service.			

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agency provider of Community Transition Services	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	●	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Benefits Planning Services**

Service Definition (Scope)*:*

Benefits Planning Services offer members in-depth guidance about public benefits, includingSocial Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid etc. Services are available to members considering or seeking competitive employment and can assist members with making informed choices regarding public benefits and provide an understanding of available work incentives.

Benefits Planning services include:

- Development of an individualized assessment, and benefits analysis. Plan must identify

the member's projected financial goal or actual financial status, explain any current public benefits, and outline of a plan describing how to use work incentives.

- Training and education on work incentives available through Social Security Administration (SSA), and on income reporting requirements for public benefits programs.
- Assistance with developing a Plan to Achieve Self Support (PASS) plan and other Work Incentives to achieve employment goals.
- Assistance with developing a budget.
- Assist with understanding health care coverage options (Medicaid, Medicaid Expansion and other State Plan Buy-in options).
- Making referrals and providing information about other resources in the community.
- Referrals to Protection and Advocacy for Beneficiaries of Social Security (PABSS) organization.
- Ongoing support and follow-up to assist the member with managing changes in their benefits, the work incentives they use, negotiating with SSA, and other benefit program administrators.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and document the member's progress toward their goals. Care coordination focuses on assessing an individual's needs, developing a personalized care plan, and connecting them to various services. Benefits planning is centered around helping individuals navigate and manage public benefits such as Medicaid, Social Security Disability Insurance, and Supplemental Security Income, ensuring they make informed decisions when considering employment or changes in their benefits status. Essentially, while Care Coordination builds the support framework around a person to address daily living and recovery needs, Benefits Planning provides the financial counseling and guidance necessary to optimize benefits.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

X	Categorically needy *(specify limits):*

Benefits Planning services are limited to a maximum of 8 hours per day (32 units daily). This service is reimbursable at a 15-minute unit rate.

Service authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this servicein more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i).

At this time the state has identified no duplication between this service offered in the 1915(i)and any services offered in the state's HCBS 1915(c) Waivers.

- If the HCBS 1915(c) Waivers were to offer a similar service in the future, the state will implement the following approach to ensure that 1915(i) services are not duplicated: The Care Coordinator will look in MMIS to see if the member

has any eligibility spans for any of the 1915(c) waivers in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider andthe participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:

- Telephone
- Secure Video Conferencing

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member,rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate use of telehealth include:

Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow- ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.

- Members amid a crisis or addiction relapse will be able to moreeasily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.

Limitations applicable to telehealth service delivery of services:

- Telehealth cannot be used for more than 25% of all benefits planning services in a calendar month.

X	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Benefits Planning Services Medical Services Division defines billing group provider as an individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently			A provider of this service must meet all thefollowing criteria: 1. Have a North Dakota Medicaid provideragreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in theservice scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request.

without being affiliated to a clinic, hospital or other agency. Licensed practitioners (OLP) in the ND Medicaid State Plan			

and are allowed to provide any state plan service that is within their scope of practice. These practitioners areallowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital, or other agency to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individual		Certified Work Incentives Counselor (CWIC) or Community Partner Work Incentives Counselor (CPWIC) or SSI/SSDI Outreach Access and Recovery (SOAR).	The individual providing the service must: 1) Be at least 18 years of age 2) Be employed by an enrolled ND Medicaid enrolled billing group of this service. 3) Have knowledge and competency in person-centered plan implementation

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Medical Services Division enrolled agency provider of Benefits Planning Services	North Dakota Provider of Benefits Planning Services	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.
Service Delivery Method. *(Check each that applies)*:		
Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Prevocational Training**
Service Definition (Scope)*:*	
Pre-vocational services are time-limited community-based services that prepare a member for employment or volunteer work. This service specifically provides learning and work experience where the member can develop general, non-job-task-specific strengths and soft skills that thatcontribute to employability in competitive work environment as well as in the integrated community settings. Prevocational services are authorized by the Care Coordinator as a support for achieving soft skills needed to attain future employment or volunteer work opportunities. Services are designed to be delivered in and outside of a classroom setting. Services must honor the member's preferences (scheduling, choice of service provider, direction of work, etc.) and provide consideration for common courtesies such as timeliness and reliability. Services furnished throughMedicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Public Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the	

member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.
Service components include:

- Teach concepts such as: work compliance, attendance, task completion, problem solving, and safety, and, if applicable, teach members how to identify obstacles to employment, obtain paperwork necessary for employment applications, and how to interact with people in the work environment.
- Coordinate scheduled activities outside of an member's home that support acquisition, retention, or improvement in job-related skills related to self-care, sensory-motor development, daily living skills, communication community living, improved socialization and cognitive skills. This could include financial skills including maintaining a bank account.
- Gain work-related experience considered crucial for job placement (e.g., volunteer work, time-limited unpaid internship, job shadowing) and career development
- General Habilitative Focus: The services are expressly designed to build transferable soft skills. The emphasis is on acquiring concepts and experiences that contribute to long-term employability and integration into community settings—not on providing technical or job-specific vocational training.
- Time-Limited and Community-Based: The service is temporarily provided in community settings (which may include classroom and experiential environments) aimed at gradually preparing the member for competitive employment or volunteer work. This clearly contrasts with vocational services that target immediate job skills development.
- Services do not include transporting the member.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

■ Categorically needy *(specify limits):*

Services are available to members 6 months before their 18th birthday, or older, or receipt of a high school diploma or GED, whichever comes first.

Services are time-limited. The staff providing services should ensure that services are needed and related to the goal that is in the person-centered plan. Pre-vocational services may be provided one on one or in a classroom setting.

The total hours (for prevocational services) are limited to no more than eight (8) hours per day (32 units daily). This service is a 15-minute unit rate.

Service authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

Members receiving Pre-Vocational services through the HCBS DD Waiver cannot receive the service through the 1915(i).

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this servicein more than one authority and are required to utilize the service through the alternate authorityrather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service, which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). The state has identified thePre-Vocational service, age 17.5+ or receipt of a high school diploma or GED, whichever comes first, within the 1915(i) is duplicative of the following services within the HCBS 1915(c) Waivers: ID/DD Waiver Pre-Vocational Services.

The state will implement the following approach to ensure that 1915(i) services are not duplicative with other Medicaid-funded services:

> The Care Coordinator will contact the State Medicaid Office to inquire if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure theplan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's

participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for training that is not directly related to a member's supported employment program

Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:
- Telephone
- Secure Video Conferencing

For each utilization, providers must document that the telehealth option was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate use of telehealth include:
- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others.Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow- ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.

- Members amid a crisis or addiction relapse will be able to more easily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.

Agencies must have records available for Medical Service Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

Medically needy *(specify limits):*

Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

North Dakota Medicaid enrolled agency provider of Prevocational Training Medical Service Division defines billing group provider as an individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independentlywithout being affiliated to a clinic, hospital or other agency.	Group Providers must: Be licensed under NDAC 75-04-01, or have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA) or Council on Quality Leadership (CQL) Accreditation, or if the group provider cannot meet the licensure or accreditation requirements, they may enroll as a 1915(i) group provider provided the individual Service Providers and their supervisors meet the individual requirements. Accreditation requirements do not apply to North Dakota Schools enrolled as Medicaid 1915(i) group providers of the service, however; schools must ensure that the Individual Service Providers affiliated with their group and their supervisors meet		A provider of this service must meet all the following criteria: Have a North Dakota Medicaid provideragreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within theirscope of practice • individual practitioners will have the required competencies identified in theservice scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request. • agencies not licensed as a DD Provider under NDAC 75-04-01, or accredited, or a school, will ensure each Individual Provideraffiliated with their group possesses one of the required individual certifications identified in the Individual Provider qualification section

independentlyLicensed practitioners'(OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitionersare allowed to enroll as their own billing group provider if they choose.If a providerisnot an OLP, they must be affiliated to a clinic, hospital or other agencyto enroll. Each billing group provider must meet the qualifications specified in the 1915(i) stateplan pages. The minimum qualifications for the provider are	individual requirements.		

listed under each service.			

Individuals		Must have one of the following certifications: - Employment Specialist; - Brain Injury Specialist; - Direct Support Provider (DSP); - Career Development Facilitation	The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of thisservice; and 2) Be at least 18 years of age; and 3) Complete Mental Health First Aid Training for Youth and/or mental Health First Aid Training for Adults, depending on scope of services/target population; and 4) Have a High School Diploma or GED. In addition to the requirements listed above, and in lieu of one of the approved certifications, a staff providing services may instead be employed by a school in North Dakota, who is a North Dakota Medicaid enrolled provider of 1915(i) Pre-Vocational Services, at a paraprofessional level and be trained in Mental Health First Aid Training for Youth and/ or Adults depending on the scope of services/ targeted population. In addition to the requirements listed above, and in lieu of one of the approved certifications, an Individual Service Provider may enroll if: They are employed by a 1915(i) enrolled Group Provider who meets the licensure or accreditation requirements. Supervisors of Individual Providers must meet the Individual Provider requirements and have two or more years of experience working in a vocational setting.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agency provider of Prevocational Training Services	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:			
Participant-directed	X	Provider managed	

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Supported Education**

Service Definition (Scope)*:*

Supported Education Services are individualized and promote engagement, sustain participation and restore an member's ability to function in the learning environment. Services must be specified in the person-centered plan of care to enable the member to integrate more fully into the community and/or educational setting and must ensure the health, welfare, and safety of the member. The goals of Supported Education are for members to: (1) engage and navigate the learning environment (2) support and enhance attitude and motivation (3) develop skills to improve educational competencies (social skills, social-emotional learning skills, literacy, study skills, timemanagement); (4) promote self-advocacy, self-efficacy and empowerment (e.g., disclosure, reasonable accommodations, advancing educational opportunities); and (5) build community connections and natural supports.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needsassessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and document the member's progress toward their goals.

Supported Education Services are requested by the Care Coordinator as a support to achieve educational goals identified in the person-centered planning process. Services are designed to be delivered in and outside of the classroom setting and may be provided by schools and/or agencies enrolled as Medicaid providers of 1915(i) Supported Education Services, that specialize in providing educational support services. Services must honor the member's preferences (scheduling, choice of service provider, direction of work, etc.) and provide consideration for common courtesies such as timeliness and reliability. Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur Providers must coordinate efforts with the Department of Public Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

Supported Education services may include, but are not limited to, any combination of the following:

Engage, bridge and transition

- Act as a liaison/support in the educational learning environment.
- Facilitate outreach and coordination.
- Familiarize individual and caregiver (if applicable) to school settings, to help navigate the school system and student services.
- Assist with admission applications and registration.
- Assist with transitions and/or withdrawals from programs such as those resulting from behavioral health challenges, medical conditions, and other co-occurring disorders.

- Improve access by effectively linking recipients of mental health services to educational programs within the school, college, or university of their choice.
- Assist with developing a transportation plan.
- Act as a liaison and coordinator between the education, mental health, treatment, and rehabilitation providers.
- Assist with advancing education opportunities including applying for work experience, vocational programs, apprenticeships, and colleges.

Support and enhance attitude and motivation

- Develop an education/career plan and revise as needed in response to members' needs and recovery process.
- Assist in training to enhance interpersonal skills and social-emotional learning skills (effective problem solving, self-discipline, impulse control, increase social engagement, emotion management, and coping skills).
- Individualize behavioral supports in all educational environments including but not limited to classroom, lunchroom, recess, and test-taking environments.
- Conduct a need assessment/educational assessment, based on goals to identify education/training requirements, personal strengths, and necessary support services.

Develop skills to improve educational competencies

- Work with members to develop the skills needed to remain in the learning environment(e.g., effective problem solving, self-discipline, impulse control, emotion management, coping skills, literacy, English-learning, study skills, note taking, time and stress management, and social skills).
- Provide training on how to access transportation (e.g., training on how to ride the bus).
- Provide opportunities to explore individual interests related to career development and vocational choice.

Self-Advocacy, self-efficacy, and empowerment

- Act as a liaison to assist with attaining alternative outcomes (e.g., completing the processto request an incomplete rather than failing grades if the student needs a medical leave or withdrawal).
- Manage issues of disclosure of disability.
- Provide advocacy support to obtain accommodations (such as requesting extensions for assignments and different test-taking settings if needed for documented disability).
- Advocacy and coaching on reasonable accommodations as defined by Americans with Disabilities Act (ADA) (e.g., note-taking services, additional time to complete work in class and on tests, modifications in the learning environment, test reading, taking breaksduring class when needed, changes in document/ assignment format, etc.).
- Provide instruction on self-advocacy skills in relation to independent functioning in the educational environment.

Community connections and natural supports

- Serve as a resource clearinghouse for educational opportunities, tutoring, financial aid, and other relevant educational supports and resources.
- Provide access to recovery supports including but not limited to cultural, recreational, and spiritual resources.
- Provide linkages to education-related community resources including supports for learning

and cognitive disabilities.

- Identify financial aid resources and assist with applications for financial aid.
- Assist in applying for student loan forgiveness on previous loans because of disabilitystatus.

Ongoing supported education service components are conducted after a member is successfully admitted to an educational program.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):

X Categorically needy *(specify limits):*

This service is available to individuals ages 5 and above.

Services are limited to 8 hours per day (32 units daily). This service has a 15-minute unit rate. Service authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO.

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). At this time the state has identified no duplication between this service offered in the 1915(i) and any services offered in the state's HCBS 1915(c) Waivers.

If the HCBS 1915(c) Waivers were to offer a similar service in the future, the state will implement the following approach to ensure that 1915(i) services are not duplicated: The Care Coordinator will look in MMIS to see if the member has any eligibility spans for any of the C waivers. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kepton file.

Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:

- Telephone

- Secure Video Conferencing

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate use of telehealth include:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.
- Members amid a crisis or addiction relapse will be able to more easily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.

Agencies must have records available for Medical Service Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

X	Medically needy *(specify limits):*

Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

North Dakota Medicaid enrolled agency provider of Supported Education Medical Services Division defines billing group provider as an individual or entity that is able to enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency.,	Group Providers must: Be licensed under NDAC 75-04-01; or have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA) or the Council on Quality Leadership (CQL) Accreditation; or if the group provider cannot meet the licensure or accreditation requirements, they may enroll as a 1915(i) group provider provided the Individual Service Providers and their supervisors meet the individual requirements. Licensing or Accreditation requirements do not apply to North Dakota Schools	None	A provider of this service must meet all the following criteria: Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) policies and procedures, including but notlimited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request. • agencies not licensed as a DD Provider under NDAC 75-04-01, or accredited, or a school, will ensure each Individual Provider affiliated with their group possesses one of the required individual certifications identified in the Individual Provider qualification section

Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency to enroll. Each billing group provider must meet the qualifications	enrolled as Medicaid 1915(i) group providers of the service, however; schools must ensure that the Individual Service Providers affiliated with their group and their supervisors meet individual requirements.		
specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			

Individual		Must have one of the following certifications: - Employment Specialist or - Brain Injury Specialist or - Direct Support Provider (DSP)	The individual providing the service must: • Be employed by an enrolled ND Medicaid enrolled billing group of this service; and • Be at least 18 years of age; and • Complete Mental Health First Aid Training for Youth and/or mental Health First Aid Training for Adults, depending on scope of services/target population; and • Have a High School Diploma or GED. In addition to the requirements listed above, and in lieu of one of the approved certifications, a staff providing services may instead be employed by a school in North Dakota who is an enrolled group provider of the service, at a paraprofessional level and be trained in Mental Health First Aid Training for Youth and/ or Adults depending on the scope of services/ targeted population. In addition to the requirements listed above, in lieu of one of the approved certifications, an Individual Service Provider may enroll if: They are employed by a 1915(i) enrolled Group Provider who meets the licensure or accreditation requirements. Supervisors of Individual Providers must meet the Individual Provider requirements and have two or more years of experience working in an educational setting.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agency provider of Supported Education	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	**Supported Employment**

Service Definition (Scope)*:*

Supported Employment services assist members to obtain and keep competitive employment at or above the minimum wage at or above the customary wage and level of benefits paid by the employer for same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment in an integrated setting in the general workforce, in a job that meets personal and career goals. After intensive engagement, ongoing follow-along support is available for an indefinite period as needed by the member to maintain their paid competitive employment position. Supported Employment services are individualized, person-centered services providing supports to members who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.

Supported Employment services can be provided through many different service models. Some of these models can include evidence-based supported employment, or customized employment for members withsignificant disabilities. Supported Employment services may be offered in conjunction with Assertive Community- based Treatment (ACT) models, Integrated Dual Diagnosis Treatment (IDDT) or with other treatment/therapeutic models that promote community inclusion and integrated employment.

Personal care assistance is not included as a component of Supported Employment services.

Supported employment supports does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Supported employment support does not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

A member's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and document the member's progress toward their goals.

Supported Employment services may be furnished to any member that elects to receive support and demonstrates a need for the service. Services are authorized during the person-centered planning process by the Care Coordinator to assist the member with achieving goals identified inthe person-centered plan of care. Services must be provided in a manner which honors the member's preferences (scheduling, choice of provider, direction of work), and consideration for common courtesies such as timeliness and reliability. Services furnished through Medicaid 1915(i)must not duplicate services funded under Section 110 of the Rehabilitation Act of 1973 or the

IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur, providers must coordinate efforts with the Department of Instruction and/or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under Section 110 of the Rehabilitation Act of1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file.

Supported Employment services are individualized and may include any combination of the following services:

- vocational/job-related discovery or assessment,
- person-centered employment planning,
- job placement,
- rapid job placement,
- job development,
- negotiation with prospective employers,
- job analysis,
- job carving,
- support to establish or maintain self-employment (including home-based self-employment),
- training and systematic instruction,
- job coaching,
- benefits planning support/referral,
- Guidance on income reporting
- training and planning,
- asset development and career advancement services,
- education and training on disability disclosure,
- education and training on reasonable accommodations as defined by ADA,
- assistance with securing reasonable accommodations as defined by ADA, and/or
- other workplace support services including services not specifically related to job skilltraining that enable the participant to be successful in integrating into the job setting.

Prior to a member's first day of employment, the provider will work with the member and members of the member's team to create a plan for job stabilization. The provider will continue to coordinate team meetings, when necessary, follow-up with the member once they are employed, and provide monthly progress reports to the entire team.

Ongoing Follow-Along Support services are available to a member once they are employed and are provided periodically to address work-related issues as they arise (e.g., understanding employer leave policies, scheduling, time sheets, tax withholding, etc.). Ongoing Follow-Along Support may also involve assistance to address issues in the work environment, including accessibility, employee – employer relations. Services are designed to identify any problems or concerns early, to provide the best opportunity for long lasting work opportunities.

- Also included are supports to address any barriers that interfere with employment success/maintaining employment, which may include providing support to the employer.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, durationand scope than those services available to a medically needy recipient, and services must be equalfor any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

Categorically needy *(specify limits):*

Services are available to members 14 years of age or older.

A unit of Supported Employment is a 15-minute unit. A maximum of eight (8) hours per day (32 units daily). Service authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/ out of community placement will be reviewed by the Medical Services Division or contracted MCO.

Once a member has maintained employment for 6 months the member may receive ongoingfollow-along support. Ongoing support services are billed 15-minute units and may not exceed a maximum of 20% of hours worked by the member per week.

This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities.Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). The state has identified the Supported Employment service, age 14+ within the 1915(i) is duplicative of the following services within the HCBS 1915(c) Waivers: ID/DD Waiver Supported Employment/Individual Employment Supports; and HCBS Aged/Disabled Waiver.

The state will implement the following approach to ensure that 1915(i) services are not duplicative with other Medicaid-funded services: The Care Coordinator will check MMIS to see if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider andthe participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:

- Telephone
- Secure Video Conferencing

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate use of telehealthinclude:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chances they will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.
- Members amid a crisis or addiction relapse will be able to moreeasily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- Payments that are passed through to users of employment services.

Agencies must have records available for Medical Services Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

■ Medically needy *(specify limits):*

Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify)*

North Dakota Medicaid enrolled agency provider of Supported Employment Medical Services Division defines billing group provider as an individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic,	Group Providers must: Be licensed under NDAC 75-04-01; or have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA) or The Council on Quality Leadership (CQL) Accreditation: or if the group provider cannot meet the licensure or accreditation requirements, they may enroll as a 1915(i) group provider provided the Individual Service Providers and their supervisors meet the individual requirements.		A provider of this service must meet all the following criteria: Have a North Dakota Medicaid provideragreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within theirscope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordancewith state policies and procedures • agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review. • agencies not licensed as a DD Provider under NDAC 75-04-01, or accredited, or a school, will ensure each Individual Provider affiliated with their group possesses one of the required individual certifications identified in the Individual Provider qualification section.

	hospital or another agency. , Licensed practitioners (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan	Accreditation requirements do not apply to North Dakota Schools enrolled as Medicaid 1915(i) group providers of the service, however; schools must ensure that the Individual Service Providers affiliated with their group and their supervisors meet individual requirements.		

service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group providerif they choose.If a provider is not an OLP, they must be affiliated to a clinic, hospitalor other agency to enroll. Eachbilling group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualificationsfor the provider are listed under each service.			

Individuals		Must have one of the following certifications: -Employment Specialist or -Brain Injury Specialist or - -Direct Support Provider (DSP)or -Career Developmen t Facilitation	The individual providing the service must: • Be employed by an enrolled ND Medicaidenrolled billing group of this service; and • Be at least 18 years of age; and • Complete Mental Health First Aid Training for Youth and/or mental Health First Aid Training for Adults, depending on scope of services/target population; and • Have a High School Diploma or GED. In addition to the requirements listed above, and in lieu of one of the approved certifications, a staff providing services may instead be employed by a school in North Dakota who is an enrolled group provider of the service, at a paraprofessional level and be trained in Mental Health First Aid Training for Youth and/ or Adultsdepending on the scope of services/ targeted population. In addition to the requirements listed above, and in lieu of one of the approved certifications, an Individual Service Provider may enroll if: They are employed by a 1915(i) enrolled Group Provider who meets the licensure or accreditation requirements. Supervisors of Individual Providers must meet the Individual Provider requirements and have two or more years of experience working in an educational setting.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification on *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agencyprovider of Supported Employment	*North Dakota Medicaid Provider Enrollment*	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at leastonce every five (5) years.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that thestate plans to cover):*	
Service Title:	**Housing Support**
Service Definition (Scope)*:*	

Housing Supports help member's access and maintain stable housing in the community. Services are flexible, individually tailored, and involve collaboration between service providers,property managers, and tenants to engage in housing, preserve tenancy and resolve crisis situations that may arise. Housing Support services include Pre-tenancy, Tenancy.

Housing services can be provided through many different service models. Some of these modelsmay include Permanent Support Housing (PSH) for members with a behavioral health condition experiencing chronic homelessness. Services may be offered in conjunction with Assertive Community-based Treatment (ACT) models, Family Assertive Community Treatment(FACT), Integrated Dual Diagnosis Treatment (IDDT) or with other treatment/therapeutic models that help a member with stabilizing and accessing to the greater community.

A member's need for initial and continued services shall be discussed at each 1915(i) person- centered plan of care meeting, and formally evaluated during the functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a member's identified goals in the Person-Centered POC and document the member's progress toward their goals.

Pre-Tenancy services provide members the support that is needed to secure housing. Pre-tenancy services are available only to the member living in the community and may not bebilled when a member is concurrently receiving Tenancy Support services.

Pre-tenancy services include:

- Supporting with applying for benefits to afford housing, but not limited to the following: housing assistance, SSI,SSDI, TANF, SNAP, LIHEAP, etc.
- Assisting with the housing search process and identifying and securing housing of the member's choice .
- Assisting with the housing application process, including securing required

documentation (e.g., Social Security card, birth certificate, prior rental history).
- Helping with understanding and negotiating a lease.
- Helping identifying resources to cover expenses including the security deposit, moving costs, and other one-time expenses (e.g., furnishings, adaptive aids, environmental modifications).
- Services provided in Pre-tenancy Supports may not duplicate the services provided in Community Transition Supports (CTS) or in Care Coordination.

Tenancy services assist members with sustaining tenancy in an integrated setting that supports access to the full and greater community. Tenancy Supports may not be billed when a member is concurrently receiving Pre-tenancy Support services.

Tenancy services include:
- Assisting with achieving housing support outcomes as identified in the person-centeredplan.
- Providing training and education on the roles, rights, and responsibilities of the tenant andthe landlord.
- Coaching on how to develop and maintain relationships with landlords and propertymanagers.
- Supporting with applying for benefits to afford their housing including securing new/renewing existing benefits.
- Skills training on financial literacy (e.g., developing a monthly budget).
- Assisting with resolving disputes between landlord and/or other tenants to reduce the riskof eviction or other adverse action.
- Assistance with the housing recertification process.
- Skills training on how to maintain a safe and healthy living environment (e.g., training on how to use appliances, how to handle repairs and faulty equipment within the home, how to cook meals, how to do laundry, how to clean in the home). Skills training should be provided onsite in the member's home.
- Coordinating and linking members to services and service providers in the communitythat would assist a member with sustaining housing.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

The determination of the need for Housing Services must be identified through the person-centered planning process for members receiving services and supports.

Services are available to members six months prior to their 18th birthday.

Members eligible to receive 1915(i) state plan amendment services may elect to receive housing support services if the member:
- is experiencing homelessness,
- is at risk of becoming homeless,
- is living in a higher level of care than is required, or
- is at risk for living in an institution or other segregated setting.

To receive services, a person must be living in, or planning to receive services in a setting thatcomplies with all home and community-based setting (HCBS) requirements identified by the

Federal Centers for Medicare & Medicaid Services in the Code of Federal Regulations, title 42,section 441.301 (c).

The setting must be integrated in and support full access to the greater community; ensure a member's rights or privacy, dignity and respect, and freedom from coercion and restraint; optimize individual initiative, autonomy, and independence to make life choices; and facilitate individual choice about services and supports and who provides them. Provider-controlled settings must meet additional requirements.

Prior to billing, services must be approved in the person-centered POC by the Care Coordinator.The Care Coordinator will ensure the plan reflects both short and long-term goals for maintaining and securing housing supports. In addition, prevention and early intervention strategies must be included in the POC in the event housing is jeopardized.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard State plan service questions related to sufficiency of services.

(Choose each that applies):

●	Categorically needy *(specify limits):*

	Housing Supports are limited to eight (8) hours per day (32 units daily). This service has a 15-minute rate. Service authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the Medical Services Division or contracted MCO. Services may not be duplicated by any other services provided through the Home & Community Based Services 1915(c) waiver. Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager This service cannot be provided to a member at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. Members eligible for multiple Medicaid funded authorities cannot access this service in more than one authority and are required to utilize the service through the alternate authority rather than the 1915(i). For example, if a member is enrolled in both the 1915(i) and a 1915(c) waiver and needs this service which is offered in both, the member is required to access the service through the 1915(c) rather than the 1915(i). The state will implement the following approach to ensure that 1915(i) services are not duplicated: • The Care Coordinator will look at MMIS to inquire if the member has any eligibility spans for any of the 1915(c) waiver authority in MMIS. If yes, the Care Coordinator will reach out to the 1915(c) Waiver authority and do due diligence to ensure the plan of care does not include duplicative services. Services furnished through Medicaid 1915(i) must not be duplicated by services funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member through these agencies under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the member's record and kept on file. Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

Telehealth includes real-time, two-way communication between the service provider and the participant. Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services. The privacy of members must be respected at all times, and Telehealth services must be delivered in a manner that respects their natural privacy. The state does not permit the usage of telehealth in instances of toileting, dressing, and any other Activities of Daily Living (ADL). Telehealth services for 1915(i) in North Dakota utilize secure video conferencing and telephone check-ins to assess individual needs and coordinates with in-person caregivers for hands-on support, when necessary, while respecting the wishes of the member. If an individual is unable to utilize the telehealth technology either by themselves or with help, then this would not be an option for the individual's team and would be noted in the plan of care. If a member chooses telehealth as an option for service delivery, their plan of care must address the member's health, safety and behavioral needs while telehealth is utilized so appropriate assistance can be provided. The plan of care must document: Remote modality (telephone or secure video conference), Schedule of telehealth visits, member has a charged phone or alert device, sessions take place in a private space, behavioral supports, such as de-escalation steps and checks-in at the start and end of each call, and a backup plan if the technology fails, or a safety issue arises.

Telehealth options include:

- Telephone
- Secure Video Conferencing

Telehealth must:

- be elected by the member receiving services;
- not block the member's access to the community;
- not prohibit needed in-person services for the member;
- utilize a HIPPA compliant platform; and
- prioritize the integration of the member into the community.

For each utilization, providers must document that the telehealth option:

- was elected by the member receiving services;
- did not block the member's access to the community;
- did not prohibit needed in-person services for the member;
- utilized a HIPAA-compliant platform; and
- prioritized the integration of the member into the community.

The keys to providing better member care lies in making services available and ensuring members seek help when necessary. Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize telehealth must enhance their integration into the community. Examples of the appropriate useof telehealth include:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services to hide their conditions from
  others. Telehealth will allow these members to receive services from the comfort of their own surroundings, reducing the stigma and increasing the chancesthey will seek services and stay engaged. Telehealth alternatives will make ongoing care and follow-ups more convenient and easier to schedule for the member, likely increasing the number of appointments made, as well as the number of appointments kept.

	• Members amid a crisis or addiction relapse will be able to moreeasily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care. Agencies must have records available for Medical Services Division or contracted MCO review documenting that individual providers have knowledge of and competency in the following: o Person-Centered Plan Implementation
X	Medically needy *(specify limits):*
	Same limits as those for categorically needy.
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Housing Supports Medical Services Division defines billing group provider asan individual or entity that can enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll independentl y without being affiliated toa clinic, hospital or other agency.	None	None	A provider of this service must meet all the following criteria: o Have a North Dakota Medicaid provider agreement and attest to the following: o individual practitioners meet the required qualifications o services will be provided within their scope of practice o individual practitioners will have the required competencies identified in the service scope o agency conducts training in accordance with state policies and procedures o agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for Medical Services Division review upon request o agency availability, or the identification of another community resource available 24 hours a day, 7 days a weekto clients in need of emergency services o Member of the North Dakota Continuum of Care (NDCOC)

Licensed practitioners (OLP) in the ND MedicaidState Plan and are allowed to provide any state plan service that iswithin their scopeof practice.			

These practitionersare allowed to enroll as their own billing group provider if they choose.If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i)state plan pages. The minimum qualifications for the provider are listed under each service.			

Individuals		Mental Health First Aid Training for Youth and/or Mental Health First Aid Training for Adults, depending on scope of services/ targeted population	Be employed by an enrolled billing group provider; be 18 years of age and meet one of the following criteria: High school diploma or GED and at least: a. Two years of work experience providing direct client service; or b. Associate degree froman accredited college or university. Supervisors of staff providing Housing Support services must meet the requirements of an individual providing services and have two or more years of experience in providing direct client services to individuals experiencing homelessness.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
North Dakota Medicaid enrolled agency provider of Housing Services	Medical Services Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	●	Provider managed

2. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box, the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which*

would ordinarily be provided by a legally responsible individual):

N/A

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

☒	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c)the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements.Select one):*

	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant- directed, and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐

5. Financial Management. (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ● Participant–Directed Person-Centered Service Plan. *(By checking this box, the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of serviceproviders and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles andsharing of responsibilities in obtaining services in a self-directed manner and assures theappropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self- direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

☒	The state does not offer opportunity for participant-employer authority.	
	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
		Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result inpayment for medical assistance to the individual). (*Select one):*

☒	The state does not offer opportunity for participants to direct a budget.
	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Plan of Care (POC) a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.**

Requirement	***1a. POCs address assessed needs of the 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants with POCs that identify and address the participant's assessed needs. N= The number and percent of participants with POCs that identify and address the participant's assessed needs as evidenced by completed assessment indicated on the POC. D=Total number of participants.
Discovery	All plans of care are reviewed and approved by program staff on an ongoing basis. With state employees reviewing traditional member's Plan of Care, and MCO employees reviewing expansion member's Plan of Cares. The state does audits of the MCO's Plan of Care for quality assurance.

Activity	The State and MCO review 100% of the Plans of Care.
(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medical Services Division and contracted MCO review 100% of the Plans of Care that are submitted. Services are not authorized until a POC is approved.
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services Division and contracted MCO When reviewing the Plans of Care the state and MCO look at the following key areas to make sure members' needs are met. • About Me and Strength & Preference Assessment: Sections are complete. • Conflict of Interest: If present, documentation is provided. • Eligibility Dates: Confirmed as correct. • Care Coordination: Contact details and meeting info are entered correctly. • Goals: Established as SMART (Specific, Measurable, Attainable, Relevant, Timely) goals. • Units on Services: Within the allowable limits. • Providers: Listed on services or noted as TBD. • Risk Management/Crisis Plan: Section is complete. • HCBS Setting Assessment: If applicable, the Provider Owned/Controlled Setting section is complete. • Settings Modification: Section is only done if needed.

	• Quarterly Review: Section is completed for required reviews. • POC Documents: All required documents are attached to the Plan of Care.
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

Requirement	***1b. POCs are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants with POCs reviewed and revised on or before the required annual review date. N= Number of participants with POCs reviewed and revised on or before the required annual review date D= Total number of participants who were eligible for more than 12 consecutive months
(Source of Data & sample size)	**Sample Size:** 100% of all plans of care for members that remain eligible for 12 consecutive months
Monitoring **Responsibilities**	Medical Services Division and contracted MCO conduct a systematic review of each POC. This involves examining documentation, verifying the review dates, and ensuring that any revisions reflect updated participant information. This step helps confirm that every plan meets the annual review requirements. The state has developed a system to monitor and track the MCO's approval of POCs.

(Agency or entity that conducts discovery activities)	
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services and contracted MCO use standardized data collection tools to capture critical elements within each POC. Ongoing, continual
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

Requirement	***1c. POCs document choice of services and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of signed POCs containing a Choice of Service and Provider Statement signed by the participant or the legally authorized guardians/representative as proof of choice of eligible services and available providers. N=*Total Number of Signed POCs including Choice of Service and Provider statements that are signed by the participant or the legally authorized guardians/representatives* D=*the total number of signed POCs.*
Discovery Activity	All plans of care are reviewed and approved by Medical Services Division staff and contracted MCO staff on an ongoing basis.

(Source of Data & sample size)	Sample size: 100% of all POCs
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medical Services and contracted MCO use standardized data collection tools to capture critical elements within each POC.
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities	When reviewing the Plans of Care the state and MCO look at the following key areas to make sure members' needs are met. • About Me and Strength & Preference Assessment: Sections are complete. • Conflict of Interest: If present, documentation is provided. • Eligibility Dates: Confirmed as correct. • Care Coordination: Contact details and meeting info are entered correctly. • Goals: Established as SMART (Specific, Measurable, Attainable, Relevant, Timely) goals. • Units on Services: Within the allowable limits. • Providers: Listed on services or noted as TBD. • Risk Management/Crisis Plan: Section is complete. • HCBS Setting Assessment: If applicable, the Provider Owned/Controlled Setting section is complete. • Settings Modification: Section is only done if needed. • Quarterly Review: Section is completed for required reviews.

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	• POC Documents: All required documents are attached to the Plan of Care. Ongoing, continual
	Frequency *(of Analysis and Aggregation)*	Ongoing, continual

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement	***2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is a reasonable indication that 1915(i) services may be needed in the future.***	
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants whose applications were evaluated for eligibility N=*The number of applicants whose applications were evaluated for eligibility.* D=*The total number of applicants.*
	(Source of Data & sample size)	**Sample Size:** 100% of all applicants.

Monitoring **Responsibilities** *(Agency or entity that conducts discovery activities)*	The Human Service Zone Eligibility Workers are responsible for determining 1915(i) eligibility. The Medical Services Division monitors all applications.
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	Medical Services Division reviews all required 1915i eligibility documents submitted for 1915i applications and are reviewed daily. Medical Services Division runs and reviews reports that compares the number of 1915i applications and applications approved. Ongoing, continual
timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

Requirement	***2b. The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.***
Discovery	

	Discovery Evidence *(Performance Measure)*	The number and percent of participant eligibility reviews completed according to the process and instruments described in the state plan amendment. N= Number of needs-based eligibility decisions that were accurately determined by applying the correct criteria as defined in the approved 1915i state plan D= Total number of needs-based eligibility determinations
	Discovery Activity *(Source of Data & sample size)*	100% of all 1915i applications are reviewed by Eligibility Workers to determine eligibility, and are reviewed by the Medical Services Division.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The Human Service Zone Eligibility Workers are responsible for determining 1915(i) eligibility, and the Medical Services Division reviews all applications.
	Frequency	Ongoing, continual
Remediation		
	Remediation Responsibilities	Medical Services Division reviews all required 1915i eligibility documents submitted for 1915i applications and they are reviewed daily. Medical Services Division runs and reviews annual reports that compares the number of 1915i applications and applications approved.

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Ongoing, continual
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

Requirement	***2c. The 1915(i) benefit eligibility of enrolled participants is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants whose eligibility was reviewed at least annually. N= Number of needs-based reevaluations that were accurately determined by using the processes and instruments described in the approved 1915i state plan. D= Total number of members who were eligible for more than 12 consecutive months
Discovery Activity *(Source of Data & sample size)*	100% of all applicants are reviewed.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medical Services Division reviews all required 1915i documents submitted for 1915i reevaluation. These are reviewed daily.
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services Division reviews all required 1915i documents submitted for 1915i reevaluations. These are reviewed daily. Ongoing, continual
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

3. Providers meet required qualifications.

Requirement	***3. Providers meet required qualifications (initially and ongoing).***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service providers who met required licensure and/or authorization standards prior and ongoing to furnishing 1915(i) services. N=*The total number of service providers who met required qualifications prior to furnishing 1915(i) Services.* D=*The total number of 1915(i) provider applications and revalidations.*

Discovery **Activity** *(Source of Data & sample size)*	100% of service providers who meet required licensure and/or authorization standards prior and ongoing to furnishing 1915(i) services.
Monitoring **Responsibilities** *(Agency or entity that conducts discovery activities)*	Medical Services Division routinely verifies and corrects any discrepancies to ensure the compliance data is complete and accurate.
Frequency	Initially upon enrollment and at scheduled revalidation
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services Division routinely verifies and corrects any discrepancies to ensure the compliance data is complete and accurate.
Frequency *(of Analysis and Aggregation)*	Annually and at scheduled revalidation

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	***4. Settings meet the home and community-based setting requirements as specified in the SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***

Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants whose POC indicate a setting for service delivery that meets the home and community-based settings requirements as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2) prior to enrollment. N= Number of participants whose service settings documented in the POC meet HCB setting requirements as outlined in the SPA and 42 CFR 441.710(a)(1) and (2) prior to enrollment. D= Total number of participants
Discovery Activity *(Source of Data & sample size)*	Ongoing, continual reviewing 100% of plan of cares are reviewed.
Monitoring	Medical Services Division and contracted MCO review all POCs for HCBS setting requirements.
Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities	Medical Services and contracted MCO review all POCs before providers can provide services.

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	***5a. The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of collaborative meetings with the Medical Services Division, the contracted MCO, and Human Service Zones held to discuss operational and administrative functions. **Numerator:** The number of collaborative meetings actually held with the Medical Services Division, the contracted MCO, or the Human Service Zones where operational and administrative functions were discussed. **Denominator:** The total number of collaborative meetings scheduled or planned with these entities during the same period.
Discovery Activity *(Source of Data & sample size)*	Medical Services Division 100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medical Services Division
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services Division
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

Requirement	***5b. The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance*	Number and percent of required MCO quality reports reflecting state policies were followed and submitted to the State Medicaid Agency timely. **Numerator:** Number of required submissions that fully reflect the State's policy requirements and were received by the State Medicaid Agency on or before the official due date.

	Measure)	**Denominator:** Total number of MCO quality-report submissions required during the reporting period.
	Discovery Activity *(Source of Data & sample size)*	Medical Services Division 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medical Services Division
	Frequency	Ongoing, continual
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services Division
	Frequency *(of Analysis and Aggregation)*	Ongoing, continual

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	***6. The SMA maintains financial accountability through payment of claims for provider managed services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims for provider managed services paid during the review period according to the service rate. N=Number of claims for provider managed services that were authorized and paid during the reviewperiod according to the service rate D=Number of claims for provider managed services that were authorized and submitted during thereview period
Discovery Activity *(Source of Data & sample size)*	Number and percent of claims paid according to the approved rate methodology for services provided.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medical Services Division and contracted MCO
Frequency	Annually
Remediation	
Remediation Responsibilities	Medical Services Division and contracted MCO

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement		***7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of critical incident reports that identify ANE and unexplained death where follow up was completed within state established timeframes. N= The number of critical incident reports identifying ANE and unexplained death for which follow-up actions were completed within state established timeframes. D= The total number of critical incident reports identifying ANE and unexplained death reported during the same period..
	Discovery Activity *(Source of Data & sample size)*	All plans of care are reviewed and approved by the state and the MCO on an ongoing basis to ensure this acknowledgment. Number and percent of critical incident reports that identify ANE and unexplained death where follow up was completed within state established timeframes.

Monitoring Responsibilities	Medical Services Division and contracted MCO
(Agency or entity that conducts discovery activities)	
Frequency	Ongoing, continual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Medical Services Division and contracted MCO
Frequency *(of Analysis and Aggregation)*	Ongoing, continual

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Performance Measures:
Medical Services Division has developed performance measures for each required sub-assurance. Each performancemeasure is stated as a metric (number and/or percentage), and specifies a numerator and dominator, ensuring the performance measure:

- is measurable,
- has face validity,
- is based on the correct unit of analysis,
- is based on the listed sample size,
- provides data specific to the state plan benefit undergoing evaluation,

- demonstrates the degree of compliance for each period of data collection, and
- measures the health of the system, as opposed to measuring a beginning step in the process.

Discovery and Remediation
Medical Services Division and contracted MCO will review samples and for measures below compliant levels. Deficiencies discovered will be addressed by providing additional training and supports to contracted entities as appropriate, providers and staff to ensure quality requirements are met.

2. Roles and Responsibilities

The Medical Services Division and contracted MCO are accountable for addressing individual problems for and relating to Measures 1, 3, 4, 6, & 7 listed above and will correct identified problems by providing training, clarify policy or other system improvement methods. Medical Services Division is accountable for addressing Measure 2 and working with the eligibility entity to resolve any identified issues. Upon discovery of an issue, the Medical Services Division will contact the care coordinator or Zone to resolve the issue through training, policy clarification or other improvement measures. Issues are documented and solutions are shared through training, policies, and guidance.

The state's approach to addressing measures below 85% compliance according to 2014 Quality reporting Guidelines include:

- Findings of the data collection efforts will be analyzed, and the need for system change identified.
- 1915(i) Program staff will meet regularly to discuss and resolve issues.
- Solutions will be implemented, reviewed, and reevaluated on an ongoing basis.

3. Frequency

Annually, and on an ongoing basis.

4. Method for Evaluating Effectiveness of System

The state evaluates system effectiveness by using ongoing performance monitoring, data collection, and regular audits—combined with active stakeholder engagement—to determine overall program performance. Participant health, welfare, and safety will be prioritized above all else. By analyzing key quality metrics and benchmarking against established goals, the state assesses and sustains progress toward its quality objectives. The monitoring practices, including periodic reviews and incorporation of feedback from member and provider communities, enable the state to continuously revisit and refine 1915i policies as needed, ensuring that the system remains responsive to changing conditions and emerging trends.