

# 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):*

**Select one:**

<b>X</b>	<b>Not applicable</b>
	<b>Applicable</b>
	Check the applicable authority or authorities:
<input type="checkbox"/>	<b>Services furnished under the provisions of §1915(a)(1)(a) of the Act.</b> <i>Specify:</i> <i>(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);</i> <i>(b) the geographic areas served by these plans;</i> <i>(c) the specific 1915(i) State plan HCBS furnished by these plans;</i> <i>(d) how payments are made to the health plans; and</i> <i>(e) whether the 1915(a) contract has been submitted or previously approved.</i>
	N/A
	<b>Waiver(s) authorized under §1915(b) of the Act.</b> <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>

Specify the §1915(b) authorities under which this program operates ( <i>check each that applies</i> ):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<p><b>A program operated under §1932(a) of the Act.</b>  <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i></p>			
<p><b>A program authorized under §1115 of the Act. Specify the program:</b>          N/A</p>			

**3. 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 ( <i>select one</i> ):	
	● The Medical Assistance Unit ( <i>name of unit</i> ):	Medical Services Division
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	N/A
○	The State plan HCBS benefit is operated by ( <i>name of agency</i> )	
	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 is available through the Medicaid agency to CMS upon request.	

**4. 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	●	<input type="checkbox"/>	<input type="checkbox"/>	●
2 Eligibility evaluation	●	<input type="checkbox"/>	<input type="checkbox"/>	●
3 Review of participant service plans	●	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	●	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	●	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	●	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	●	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	●	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	●	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	●	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

(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 ~~North Dakota Department of Health and Human Services (NDDHHS)~~ Medical Services Division, within the North Dakota Department of Health and Human Services (NDDHHS) is the single State Medicaid Agency ~~which includes the Medical Services and Behavioral Health Divisions.~~

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.

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 contractual entities 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 services](#); 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 [NDDHHS—Medicaid Agency 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 will directly perform 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~~
- ~~#10 Quality assurance and quality improvement activities.~~

~~The Medical Services Division and Blue Cross Blue Shield ND (BCBSND) MCO will share the following operational and administrative functions:~~

- ~~— #3 Review of Participant POCs~~
- ~~•~~
- ~~—~~
- ~~• #4 Prior authorization of State plan HCBS~~
- ~~• #5 Utilization management~~

Effective: ~~October 1, 2025 June 1,~~ Approved:

- ~~#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 Behavioral Health Division will directly perform the following operational and administrative functions:~~

- ~~#3 Review of Participant POCs~~

~~The Medical Services and Behavioral Health Divisions will share performance of the following functions:~~

- ~~#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, Behavioral Health, 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.

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

5.  **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 the following~~ situations:

- 1) ~~S~~such providers are the only willing and qualified providers within the county in which the individual resides ~~to perform assessments of need and develop POCs.~~ A list of providers and their geographic areas can be found on the State's website: <https://www.hhs.nd.gov/1915i/find-a-provider1915i-providers-by-service-and-region.xlsx> ~~(live.com)~~
- 2) ~~2)~~ ~~S~~such providers are the only willing and qualified providers within the county in which the individual resides ~~to perform assessments of need and develop POCs with experience and~~

~~knowledge to provide services to individuals~~ who share a common language or cultural background.

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

- A. ~~The Department~~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 as 1915(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 ~~receive prior service authorization the member's plan of care must be approved by the contracted entity or from the Department~~Medical Services Division or contracted MCO before billing state plan HCBS ~~to~~ for recipients whom they have assessed or created a Plan of Care. The ~~care plan~~ 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. ~~The Department~~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 ~~client member~~ signs an acknowledgment on the Plan of Care indicating their free choice of provider.
- D. ~~Individuals-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. ~~NDDHHS-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 assessments and~~ developing the individual's 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. ~~The State~~ 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 ~~individuals on the~~ team consists of service providers, community supports and natural supports.

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

M. The ~~Department~~ 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 NDDHHS Medical Services Division or contracted MCO to support the assertion. The NDDHHS 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 also include the services they will provide in the Individual Goals & Services portion of the Person-Centered Plan of Care. The ~~Department~~ 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 ~~and the service Authorization~~.

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

- 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 Behavioral Health Division ~~or~~ 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/ <del>2020</del> <u>2025</u>	9/30/ <del>2026</del> <u>2025</u>	<del>11,150</del> <u>950</u>
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 not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the 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):*

<input type="checkbox"/> The State does not provide State plan HCBS to the medically needy.
<input checked="" type="checkbox"/> The State provides State plan HCBS to the medically needy. <i>(Select one):</i>
<input type="checkbox"/> 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.
<input checked="" type="checkbox"/> 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 ( <i>specify State agency or entity under contract with the State Medicaid agency</i> ): Evaluation/reevaluation of eligibility is delegated by the State Medicaid Agency to the NDDHHS Human Service Zones (Zones). The Zones are government agencies. Zone Eligibility Workers or employees will complete the evaluation/reevaluation of eligibility.

**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*):

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.

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.*

**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 make this 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.

### **Responsibility and requirements of trained, qualified practitioner**

The North Dakota Human Service Centers have identified trainers who are ~~prepared~~-qualified professionals with bachelor's degrees.

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 scoring the WHODAS 2.0 Scoring Process**

The WHODAS offers several scoring options, however, the [NDDHHS 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 ~~takes into account~~ 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/>

**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~~ 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 will also 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;

- 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 score ranges between 96-100. 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 with 1915(i)(7)(c) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The State elects to target this 1915(i) State plan HCBS benefit to include any diagnoses that fall ~~under behavioral~~under behavioral health conditions, substance abuse disorders, or brain injuries. With this election, the State will operate this program for a period of five years. At least 180 days prior to the end of this five-year period, the State may request that CMS renew this benefit for an additional five-year term in accordance with 1915(i)(7)(c).

**Target Groups:** North Dakota is targeting by diagnosis only for this 1915(i) SPA. Individuals must possess one or more qualifying diagnoses. Qualifying diagnoses include behavioral health conditions, substance abuse disorders, and brain injury.

**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 enrolled individuals 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-in services 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. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

<b>i.</b>	<b>Minimum number of services.</b> 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: <div style="border: 1px solid black; width: 100px; text-align: center; margin-top: 5px;">1</div>
<b>ii.</b>	<b>Frequency of services.</b> The state requires (select one):
<input type="checkbox"/>	<b>The provision of 1915(i) services at least monthly</b>
<input checked="" type="checkbox"/>	<b>Monthly monitoring of the individual when services are furnished on a less than monthly basis.</b>

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):

- 1.  **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):

(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.)

~~NDDHHS 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 school in integrated environments, and control their own personal resources.

~~The state~~ ~~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.

Individuals residing in institutions [(NF/ICF/IID/Psychiatric Residential Treatment Centers (PRTF)/IMD/Qualified Residential Treatment ~~Program~~(~~Program~~ (QRTP), Hospitals including the ND State Hospital which is an IMD)] 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 ~~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 Eligibility Worker 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, ~~this~~ 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~~1915(i)-eligibility determination, the individual’s ~~c~~Care ~~coordinator~~ is responsible for verifying initial and ongoing HCBS Settings compliance.

~~NDDHHS~~Medical Services Division and contracted MCO will implement ~~and the~~following 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. With the exception of~~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 self-assessment is part of the plan of care development process. This assessment helps the care coordinator determine if the member’s service setting is HCBS-compliant.

- ~~• Integrated in and supports member access to the greater community~~
- ~~• Selected by the member from options identified based on the member’s needs and preferences~~
- ~~• Right to privacy, dignity, and respect, and freedom from coercion and restraint~~
- ~~• Optimizes 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.~~

All resources applicable to HCBS Settings are located on the 1915(i) website:

This table depicts what type of Tier 1, 2, & 3 settings compliance verification is required for each of the 4 residential setting categories if the individual is receiving 1915(i) funded services in the setting. If the individual is not receiving 1915(i) services within their place of residence, then only Tier 3 compliance measures must be completed for all 1915(i) individuals regardless of where they reside or where they receive services. However, correction is required at any point settings non-compliance is identified.

*Table 1. HCBS Settings Categories and Compliance Measure*

<del>Category</del>	<del>Residential Setting Types</del>	<del>Tier 1— Setting Compliance</del>	<del>Tier 2— Setting Compliance</del>	<del>Tier 3—Individual Compliance Measures</del>
		<del>Measures 1915(i) Initial HCBS Settings Review Form &amp; Site Visit Required?</del>	<del>Measures Heightened Scrutiny Required?</del>	<del>Person-Centered Planning Process and Self-Assessment Required?</del>
<del>1</del>	<del>Private Residence: A private home or apartment that the individual lives in, which is rented or owned by the individual or legal guardian. Also, Respite Care Homes fall within this category.</del>	<del>No CMS says the state can presume that these settings are compliant, but if areas of concern are identified, they must be addressed.</del>	<del>Potentially</del>	<del>Yes—Tier 3 Compliance is completed and documented in the POC initially and at least annually thereafter for all 1915(i) individuals regardless of where they reside.</del>

2	<b><del>Provider Owned or Controlled Residential Setting:</del></b> A setting where the individual is living with an unrelated caregiver in a provider owned or controlled residential setting. (Example: Sober Living, Group Homes, Foster Homes, Treatment Foster Homes, Transitional Living Homes)	Yes (Requires a lease)	Potentially	Yes — Tier 3 Compliance is completed and documented in the POC initially and at least annually thereafter for all 1915(i) individuals regardless of where they reside.

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<p><del>3</del></p>	<p><del><b>Residential Settings Presumed to have Qualities of an Institution:</b></del></p> <ul style="list-style-type: none"> <li><del>• A setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.</del></li> <li><del>• A setting that is located in a building on the grounds of, or immediately adjacent to, a public institution.</del></li> <li><del>• Any other setting that has the effect of isolating individuals from the broader community.</del></li> </ul>	<p><del>Yes- (Requires a lease)</del></p>	<p><del>Yes—Always</del></p>	<p><del>Yes—Tier 3 Compliance is completed and documented in the POC initially and at least annually thereafter for all 1915(i) individuals regardless of where they reside.</del></p>
<p><del>4</del></p>	<p><del><b>Institutions</b>          (i) A nursing facility          (ii) An institution for mental diseases          (iii) An intermediate care facility for individuals with intellectual disabilities          (iv) A hospital</del></p> <p><del>*The department <u>NDDHHS</u> has further defined Institutions as: Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Institution for Mental Diseases (IMD), Qualified Residential Treatment Program (QRTP), Psychiatric Residential Treatment Facility (PRTF), and hospitals including the ND State Hospital which is an IMD.</del></p>	<p><del>N/A-          Individuals residing in an institution are not eligible for the 1915(i) and cannot receive 1915(i) services.</del></p>	<p><del>N/A-          Individuals residing in an institution are not eligible for the 1915(i) and cannot receive 1915(i) services.</del></p>	<p><del>N/A-          Individuals residing in an institution are not eligible for the 1915(i) and cannot receive 1915(i) services.</del></p>

**HCBS Settings Compliance Measures & Verification**

Required HCBS settings compliance measures must be completed and verification of compliance documented in the POC by the care coordinator prior to submission of the POC the POC and approval of service authorizations POC.

~~Tier One~~—The Care Coordinator completes a site visit when required and the ~~1915(i) Initial HCBS~~

State: North Dakota

§1915(i) State plan HCBS

State plan Attachment 3.1-i:

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*Settings Review form.*



~~**Tier Two**—The Care Coordinator completes a site visit and the *1915(i) Heightened Scrutiny Visit form* and process.~~

~~**Tier Three**—As part of the individual’s Person-Centered Planning process, the *POC Attachment 1—Self Assessment* is completed initially questions regarding the member’s service settings and residence are answered when plans of care are developed, and at least on an annual basis to capture the individual’s experiences that incorporate the CMS HCBS Final Rule regulations to ensure on-going compliance with the requirements.~~

**Process to follow when a 1915(i) individual is receiving services in a Category 1 Setting:**

~~Individual, privately owned homes (privately owned or rented homes and apartments in which the individual receiving Medicaid-funded HCBS lives independently or with family individuals, friends, or roommates) are presumed to be in compliance with comply with the regulatory criteria of a home and community-based setting. CMS has confirmed that states are not responsible for confirming this presumption for purposes of ensuring compliance with the regulation, so NDDHHS Medical Services Division and contracted MCO does not require the Tier 1—1915(i) Initial HCBS Settings Review form or site visit be completed.~~

~~However, there may be times where Tier 2—Heightened Scrutiny must be completed on a Category 1 setting. For example, land owned by the Life Skills Transition Center contains private residences owned by a private landlord. These residences are located in a building on the grounds of a public institution; thus, the Heightened Scrutiny process needs to be completed.~~

~~Correction is required at any point settings non-compliance is identified.~~

~~If the particular residential residential setting is known to be utilized by the department’s NDDHHS’s Developmental Disabilities or Aging Divisions, or another C-Waiver Authority, it has likely been previously determined compliant. Upon verification of the settings compliance with either division, the 1915(i) Care Coordinator may obtain verification of their compliant finding and determine it is not necessary for a second Tier 1 or Tier 2 verification to be completed. It is suggested the 1915(i) Care Coordinator ask the C-Waiver Authority whether or not whether a particular setting has been determined compliant when they contact them to verify non-duplication of services.~~

~~The 1915(i) Care Coordinator will verify individual compliance using Tier 3—the person-centered planning and self-assessment process. Each of the identified HCBS settings requirements must be addressed in the individual’s plan of care.~~

**Process to follow when a 1915(i) individual is receiving services in a Category 2 Setting:**

~~Provider owned or controlled settings may include, but are not limited to, Sober Living Homes, Group Homes, Foster Homes, Treatment Foster Homes, Respite Homes, and Transitional Living Homes. Also, settings where the beneficiary lives in a private residence owned by an unrelated caregiver (who is paid for providing HCBS services to the individual) are considered provider owned or controlled settings and will be evaluated as such.~~

~~The 1915(i) Care Coordinator will verify compliance by completing Tier 1—1915(i) Initial HCBS Settings Review form and site visit compliance verification measures; and potentially Tier 2—the Heightened Scrutiny process. The 1915(i) Care Coordinator will verify individual compliance using Tier 3—the person-centered planning and self-assessment process. Required HCBS service settings questions must be answered in the individual’s plan of care. Each of the identified HCBS settings requirements must be addressed in the individual’s plan of care.~~

~~Correction is required at any point settings non-compliance is identified.~~

~~If the particular residential setting is known to be utilized by the department's NDDHHS's Developmental Disabilities or Aging Divisions, or another C-Waiver Authority it has likely been previously determined compliant. Upon verification of the settings compliance with either division, the 1915(i) Care Coordinator may obtain verification of their compliant finding, and determine it is not necessary for a second Tier 1 or Tier 2 verification to be completed. It is suggested the 1915(i) Care Coordinator ask the C-Waiver Authority whether or not whether a particular setting has been determined compliant when they contact them to verify non-duplication of services.~~

~~The 1915(i) Care Coordinator will verify individual compliance using Tier 3—the person-centered planning process. Each of the identified HCBS settings requirements Required HCBS service settings questions must be addressed answered in the individual's plan of care.~~

### **Process to follow when a 1915(i) individual is receiving services in a Category 3 Setting:**

~~The 1915(i) Care Coordinator will verify compliance by completing Tier 1—1915(i) Initial HCBS Settings Review form and site visit compliance verification measures, Tier 2—the Heightened Scrutiny process, and the 1915(i) Care Coordinator will verify individual compliance using Tier 3—the person-centered planning and self-assessment process with each of the identified HCBS settings requirements addressed in the individual's plan of care.~~

#### *Correction at any point settings non-compliance is identified:*

~~If the particular residential setting is known to be utilized by the department's NDDHHS's Developmental Disabilities or Aging Division, or other C-Waiver Authority, it has likely been previously determined compliant. Upon verification of the settings compliance with either division, the 1915(i) Care Coordinator may obtain verification of their compliant finding and determine it is not necessary for a second Tier 1 or Tier 2 verification to be completed. It is suggested the 1915(i) Care Coordinator ask C-Waiver Authority whether or not whether a particular setting has been determined compliant when they contact them to verify non-duplication of services.~~

~~The 1915(i) Care Coordinator will verify individual compliance using Tier 3—the person-centered planning process. Required HCBS service settings questions must be answered in the individual's plan of care. Each of the identified HCBS settings requirements must be addressed in the individual's plan of care.~~

### **Process to follow when a 1915(i) individual is receiving services in a Category 4 Setting:**

~~These settings are institutions and will never be HCBS compliant. Individuals residing in an institution are not eligible for the 1915(i) and cannot receive 1915(i) services, with the exception of except for the Community Transition service under certain circumstances. See the *Community Transition policy* for details.~~

## **Responsibilities to Ensure Initial & On-Going Compliance**

### Care Coordinator Responsibilities

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 ~~identified in the table above~~ prior to service provision 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 Self-Assessment as part of HCBS Service Settings part of the Person-Centered Planning Process and POC development and review:

~~The state has developed a 1915(i) Person-Centered Planning & Self-Assessment Guide and POC Instruction Guide providing full details on completing the Self-Assessment. POC template contains HCBS service setting questions to assist care coordinators in gathering and evaluating information regarding the member's service setting(s).~~

~~The Self-Assessment, The questions are~~ completed by the care coordinator in collaboration with the individual and addresses 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 ~~be in compliance~~ 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 to public 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 to look for a job if interested, meaningful non-work activities in the community, etc.).
3. People have control and access of their money (e.g., able to buy needed items, use own money when choose 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 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, individual choice/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 rooms, etc.).
9. People have visitors of their choice and 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:

<p><b>HCBS Setting Assessment</b> <b>Questions-Rule*</b> <i>Required HCBS settings compliance verification measures must be completed prior to submission of POC and approval of service authorizations. Individual Settings Compliance Measures including Person- Centered Planning and Self-Assessment are completed for all individuals. Additional Settings Compliance Measures must be completed for individuals receiving services in their place of residence. (CMS 4a)</i></p>
<p><del>Will the individual receive 1915(i) services in a provider-owned or controlled residential setting: Is the member receiving 1915(i) services in a provider-owned or controlled residential setting?</del></p> <p><input type="checkbox"/> Yes <del>_, and I have completed a site visit and the 1915(i) Initial HCBS Settings Review form; or, I have obtained verification of compliance.</del> requires completion of additional Provider-Owned or Controlled Setting-specific questions as detailed above.</p> <p><input type="checkbox"/> No</p>
<p><b><u>Living Environment</u></b></p>
<p><del>Will the individual receive 1915(i) services in a residential setting presumed to have qualities of an institution? Do you live in a community-based setting (community-based settings meet ALL below criteria)</del></p> <p><u>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.:</u></p> <p><input type="checkbox"/> Yes <del>, and I have completed the Heightened Scrutiny process; or, I have obtained verification of compliance.</del></p> <p><input type="checkbox"/> No</p>
<p>Date Care Coordinator verified HCBS Settings Rule compliance:</p>

**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.

<b>HCBS Settings Modifications*</b>
<i>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)</i>
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 in ~~this~~ policy. Any identified issues will be remediated by using the person-centered plan of care process. An advocacy organization, Medical Services Division, or the contracted MCO ~~or the NDDHHS~~ may be contacted for issues not able to be remediated.

~~If a decision is made that the setting cannot be remedied, a denial will be issued for that setting. The care coordinator will issue a 30-day advance written notice to the individual informing them they are not able to receive 1915(i) services in that setting and must relocate to a compliant setting within 30 days if they wish to continue to receive 1915(i) services in their place of residence.~~

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.

### **NDDHHS 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 Heightened 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.

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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
3. §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR
- 4.2. §441.725(b).
- 5.3. ● 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.
- 6.4. **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*):

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.

**7.5. 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 of 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 ~~NDDHHS~~ Medical Services Division or contracted MCO-required competencies as identified within the Care Coordination service part of this application; and one of the following:
  - ~~have a bachelor's degree from an accredited college or university and 1 year of supervised experience working with special populations; or~~
  - ~~3 years of supervised experience working with special populations 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 of all~~ the following criteria ~~is able to 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 ~~NDDHHS ND Medicaid~~ 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.
  - ~~a bachelor's degree from an accredited college or university and 1 year of supervised experience working with special populations; or~~
  - ~~3 years of supervised experience working with special populations~~

**8.6. 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**

~~At the initial meeting between the Care Coordinator and the member, a signed release of information will be obtained to allow the Care Coordinator to request the eligibility related information, i.e., diagnosis and assessment score, from the Zones.~~

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 of~~ 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 ~~he/she has~~ 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 Therap.
- ~~All initial and revised POCs must be uploaded into the Medicaid Management Information System (MMIS).~~

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.

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.

**9.7. 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 NDDHHS Medical Services Division and contracted MCO-authorized providers of the chosen service.

As a recommended service is identified, the Care Coordinator will provide the participant with ~~alist~~ 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 providers at any time, including the option to change their Care Coordinator.

**10.8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** (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. ~~For Traditional Medicaid members, the POCs are uploaded into MMIS for authorization by state 1915i administrators. 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 Behavioral Health Division, which is under the SMA, reviews plans of care completed for Traditional members to ensure Requirement Measures 1, 2, 4, and 7 within the Quality Improvement Strategy section of SPA have been completed through the utilization of the 1915(i) POC checklist~~ The process for POC submission and review and prior authorization of services are the same for the initial POC and all revised POCs.

**11.9. 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*):

<input checked="" type="radio"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
	Other ( <i>specify</i> ):				

## Services

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

<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i> ):	
Service Title:	<b>Care Coordination</b>
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~~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.

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 community context) 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;
- 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 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 member's 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 ~~NDDHHS-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 ~~NDDHHS-Medical Services Division~~ or contracted MCO review as verification that Care Coordinators have reviewed ~~NDDHHS-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 authorization requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the [NDDHHS 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. For example, the participant involved in the 1915(i) to address behavioral health needs, may be enrolled in the HCBS 1915(c) waiver due to a developmental disability, be in the foster care system, and also receiving Special Education services. Each of these systems offer case management in their areas of expertise and serve an essential role in the individual's care.

The state's 1915(i) SPA will offer Care Coordination for Ages 0+ and the following ND HCBS 1915(c) Waivers currently offer Case Management: ID/DD Waiver; Medically Fragile Waiver; Autism Waiver; Children's Hospice Waiver; Aged & Disabled Waiver;

While the individual may receive case management from several areas, the state will allow only one case manager to bill during the same time period. The State will provide policy informing the 1915(c) waiver case managers, targeted case managers and the 1915(i) care coordinators that they will need to decide amongst themselves which of them will bill when attending the same meeting.

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.

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

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

~~Remote support~~Telehealth options include:

- Telephone
- Secure Video Conferencing

~~Remote support~~Telehealth must:

- be elected by the individual 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 ~~remote support~~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. ~~Remote support~~Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member’s election to utilize ~~remotesupport~~telehealth must enhance their integration into the community. Examples of the appropriate use of ~~remote support~~telehealth include:

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services ~~in an effort to~~ hide their conditions from others. ~~Remote support~~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. ~~Remote support~~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 ~~in the midst of~~ amid a crisis situation 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.

●	Medically needy ( <i>specify limits</i> ):		
	Same limits as those for categorically needy.		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):

<p>North Dakota Medicaid enrolled agency provider of Care Coordination Services</p> <p><a href="#">NDDHHS Medical Services Division</a> defines billing group provider as an individual or entity that <del>is able to</del> <del>can</del> 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, <del>and others are not. Examples of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other</del></p>	<p>None</p>	<p>None</p>	<p>A provider of this service must meet <del>all of</del> the following:</p> <ul style="list-style-type: none"> <li>• Have a North Dakota Medicaid provider agreement and attest to the following:             <ul style="list-style-type: none"> <li>○ individual practitioners meet the required qualifications</li> <li>○ services will be provided within their scope of practice</li> <li>○ individual practitioners will have the required competencies identified in the service scope</li> <li>○ agency availability, or a back-up resource available 24 hours a day, 7 days a week to clients in crisis</li> <li>○ agency conducts training in accordance with state policies and procedures</li> <li>○ 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</li> </ul> </li> </ul>
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<p><u>L</u>icensed practitioners<sup>2</sup> (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 <del>in order to</del> 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.</p>			<p>available for <a href="#">NDDHHS Medical Services Division</a> review upon request.</p>
<p>Individual</p>			<p>The individual providing the service must:</p> <ol style="list-style-type: none"> <li>1) be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and</li> <li>2) Be at least 18 years of age; and</li> <li><del>3) have a bachelor's degree from an accredited college or university</del></li> <li><u>3) Must have a bachelor's degree, and 1 year of supervised experience working with special populations; or</u></li> <li><del>4)</del></li> <li><u>4) If the individual</u></li> </ol>

Effective: ~~October 1, 2025~~ June Approved:

Supersedes: ~~24-0017~~ 23-0027

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  
manageme  
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such as  
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monitoring  
and follow-  
up  
activities.

In lieu of a bachelor's degree,  
3 years of supervised  
experience working with  
special populations  
and,  
be supervised by an  
individual containing  
these qualifications at

Effective: ~~October 1, 2025~~ June Approved:

Supersedes: 24-0017 ~~23-0027~~

			a minimum.
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**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):
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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.
<b>Service Delivery Method.</b> (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):	
Service Title:	<b>Training and Support for Unpaid Caregivers</b>
Service Definition (Scope):	
<p>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.</p> <p>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.</p> <p>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.</p> <p>Covered activities may include the following:</p> <ol style="list-style-type: none"> <li>1) practical living and decision-making skills;</li> <li>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;</li> <li>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;</li> <li>4) provide information, instruction, and guidance in performing household tasks, personal care tasks, and related basic hygiene tasks;</li> <li>5) use of community resources and development of informal supports;</li> <li>6) conflict resolution;</li> <li>7) coping skills;</li> </ol>	



<p>8) gaining an understanding of the <del>individual's</del> <del>participant</del> <del>member's</del> behavioral health needs, including medications (purpose and side effects), mental illness or substance use disorders symptomology, and implementation of behavior plans;</p> <p>9) learning communication and crisis de-escalation skills geared for working with the <del>participant's</del> <del>member's</del> behavioral health needs;</p> <p>10) training or education on a patient suicide safety plan and counseling on lethal means;</p> <p>11) systems mediation and advocacy; and,</p> <p>12) assist with accessing services, transportation arrangements, and coordination of services and appointments.</p> <p>Agencies must have records available for <del>NDDHHS</del> <a href="#">Medical Services Division or contracted MCO</a> review documenting that individual providers have knowledge of and competency in the following:</p> <ul style="list-style-type: none"><li>○ Person-Centered Plan Implementation</li></ul>	
Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):	
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 ( <i>specify limits</i> ):

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 [NDDHHS 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 ~~on the department's website~~ for the maximum allowable training 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 [NDDHHS Medical Services Division or contracted MCO](#). This service cannot be provided to a ~~participant member~~ ~~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. ~~Individuals~~ ~~Members~~ ~~Participants~~ 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 ~~an individual~~ ~~a participant member~~ is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of~~ ~~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 ~~contact the State Medicaid Office to inquire if the member has any eligibility spans for any of the C waivers in MMIS~~ [look at MMIS to determine if the participant is covered under a C Waiver authority](#). If yes, the Care Coordinator will reach out to the 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 ~~individual's~~ ~~member's~~ record and kept on file.

	<p><del>Remote support</del>Telehealth may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar month.</p> <p><del>Remote support</del>Telehealth includes real-time, two-way communication between the service provider and the participant. <del>Remote support</del>Telehealth is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services.</p> <p><del>Remote support</del>Telehealth options include:</p> <ul style="list-style-type: none"> <li>• Telephone</li> <li>• Secure Video Conferencing</li> </ul> <p><del>Remote support</del>Telehealth must:</p> <ul style="list-style-type: none"> <li>• be elected by the <del>individual member</del> receiving services;</li> <li>• not block the member’s access to the community;</li> <li>• not prohibit needed in-person services for the member;</li> <li>• utilize a HIPPA compliant platform; and</li> <li>• prioritize the integration of the member into the community.</li> </ul> <p>For each utilization, providers must document that the <del>remote support</del>telehealth option:</p> <ul style="list-style-type: none"> <li>• was elected by the member receiving services;</li> <li>• did not block the member’s access to the community;</li> <li>• did not prohibit needed in-person services for the member;</li> <li>• utilized a HIPAA-compliant platform; and</li> <li>• prioritized the integration of the <del>individual member</del> into the community.</li> </ul> <p>The keys to providing better member care lies in making services available and ensuring members seek help when necessary. <del>Remote support</del>Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member’s election to utilize <del>remotesupport</del>telehealth must enhance their integration into the community. Examples of the appropriate use of <del>remote support</del>telehealth include:</p> <ul style="list-style-type: none"> <li>• Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services <del>in an effort to</del> hide their conditions from others. <del>Remote support</del>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. <del>Remote support</del>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.</li> <li>• Members <del>in the midst of a mid a crisis situation</del> 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.</li> </ul>
x	<p>Medically needy (<i>specify limits</i>):</p> <p>Same limits as those for categorically needy.</p>
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>	

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
<p>North Dakota Medicaid enrolled agency provider of Training and Supports for Unpaid Caregivers. (RATE #1)</p> <p><u>NDDHHS-Medical Services Division</u> defines billing group provider as an individual or entity that <del>is able to</del> <u>can</u> 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, <del>and others are not.</del> <u>Examples of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity are: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other-licensed</u></p>	<p>None</p>	<p>None</p>	<p>A provider of this service must meet <del>all of</del> <u>all</u> the following criteria:</p> <p>Have a North Dakota Medicaid provider agreement and attest to the following:</p> <ul style="list-style-type: none"> <li>• individual practitioners meet the required qualifications</li> <li>• services will be provided within their scope of practice</li> <li>• individual practitioners will have the required competencies identified in the service scope</li> <li>• agency conducts training in accordance with state policies and procedures</li> <li>• 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 <u>NDDHHS-Medical Services Division</u> review upon request</li> </ul>

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practitioners' (OLP) in the ND Medicaid			
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<p><u>Licensed practitioners (OLP) in the ND Medicaid</u>        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.</p>			
<p>Individual</p>	<p>None</p>	<p>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</p>	<p>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 <del>NDDHHS</del></p>

		Visitor, Parents as Teachers Home Visitor,	<u>Medical Services</u> <del>approved</del> <u>Division approved</u> certification.
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		Nurse Family Partnerships Program Visitor, or other <u>NDDHHS Medical Services Division</u> 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.
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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.
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**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):
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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.
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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
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		once every five (5) years.	
<b>Service Delivery Method.</b> (Check each that applies):			
Participant-directed	<input checked="" type="checkbox"/>	Provider managed	<input type="checkbox"/>

**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 ~~participants~~ ~~members~~ ~~a~~ 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, and first-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 ~~participant’s~~ ~~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~~ ~~member’s~~ identified goals in the Person-Centered POC and documentthe ~~participant’s~~ ~~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 must be intended to achieve the identified goals or objectives as set forth in the ~~individual~~ person-centered plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist ~~individual~~ ~~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 an ~~individual~~ ~~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:
  - o Promoting wellness through modeling.
  - o Assisting with understanding the person-centered planning meeting.
  - o Coaching the ~~individual~~ ~~member~~ to articulate recovery goals.
  - o 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 [individualmember](#) with gaining and regaining the ability to make independent choices and assist [individualmembers](#) 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 [individualmember](#) 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 Americans with 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 [individualmembers](#) for the specific purpose of achieving increased community inclusion and participation, independence and productivity.
- Connecting [individualmembers](#) to community resources and services.
  - Accompanying [individualmembers](#) to appointments and meetings for the purpose of mentoring and support.
  - Helping develop a network for information and support, including connecting [individualmembers](#) with cultural/ spiritual activities, locating groups/programs based on [an individualmember's](#) interest including peer-run programs, and support groups.
- 6) Peer Relief Services are voluntary short-term and offer interventions to support [individualmembers](#) for averting 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, duration and scope than those services available to a medically needy recipient, and services must be equal for any [individualmember](#) 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*):

Peer support services are billed in 15-minute 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 NDDHHS Medical Services Division or contracted MCO.

Service is limited to individual members Age 18 and older.

This service cannot be provided to an individual 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. Individual 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 an individual member is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of~~ needs this 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 contact the State Medicaid Office to inquire if the member has any eligibility spans for any of the C-waivers in MMIS 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 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 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 individual member's record and kept on file.

State plan 1915(i) HCBS will not be provided to an individual 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 must meet in-person with the participant member before providing ~~remote services~~ telehealth, and then at least quarterly. ~~After the first in-person meeting the peer support specialist may provide which remote support telehealth telehealth services. may be utilized,~~ However in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

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

~~Remote support~~ Telehealth options include:

- Telephone

- Secure Video Conferencing

<p>Telehealth must:</p> <ul style="list-style-type: none"> <li>• be elected by the member receiving services;</li> <li>• not block the member’s access to the community;</li> <li>• not prohibit needed in-person services for the member;</li> <li>• utilize a HIPPA compliant platform; and</li> <li>• prioritize the integration of the member into the community.</li> </ul> <p>For each utilization, providers must document that the <del>remote support</del>telehealth option:</p> <ul style="list-style-type: none"> <li>• was elected by the member receiving services;</li> <li>• did not block the member’s access to the community;</li> <li>• did not prohibit needed in-person services for the member;</li> <li>• utilized a HIPAA-compliant platform; and</li> <li>• prioritized the integration of the <del>individual</del>member into the community.</li> </ul> <p>The keys to providing better member care lies in making services available and ensuring members seek help when necessary. <del>Remote support</del>Telehealth options are for the benefit of the member, rather than the benefit of the provider. The member’s election to utilize <del>remote support</del>telehealth must enhance their integration into the community. Examples of the appropriate use of <del>remote support</del>telehealth include:</p> <ul style="list-style-type: none"> <li>• Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services <del>in an effort to</del> hide their conditions from others. <del>Remote support</del>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. <del>Remote support</del>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.</li> <li>• Members <del>in the midst of</del>amid a crisis situation 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.</li> </ul> <p>Agencies must have records available for <del>NDDHHS Medical Services Division or contracted MCO</del> review documenting that individual providers have knowledge of and competency in the following:</p> <ul style="list-style-type: none"> <li>○ Person-Centered Plan Implementation</li> </ul>			
<p>Medically needy (<i>specify limits</i>):</p>			
<p>Same limits as those for categorically needy.</p>			
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>			
<p>Provider Type (<i>Specify</i>):</p>	<p>License (<i>Specify</i>):</p>	<p>Certification (<i>Specify</i>):</p>	<p>Other Standard (<i>Specify</i>):</p>

North Dakota Medicaid Enrolled Agency Provider of – Peer Support  <u>NDDHHS Medical Services Division</u> defines	None	None	An enrolled agency provider of this service must meet <del>all of</del> the following criteria to enroll as a provider: 1. Have a North Dakota Medicaid provider agreement and attest to the following: <ul style="list-style-type: none"><li>• individual practitioners meet the</li></ul>
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<p>billing group provider as an individual or entity that <del>is able to</del> <u>can</u> 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, <del>and others are not. Examples of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other licensed practitioners' (OLP) in the 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</del></p>			<p>required qualifications</p> <ul style="list-style-type: none"><li>• services will be provided within their scope of practice</li><li>• individual practitioners will have the required competencies identified in the service scope</li><li>• agency conducts training in accordance with state policies and procedures</li><li>• 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 <u>NDDHHS Medical Services Division</u> review upon request.</li></ul>
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their own billing group provider if they choose. If a			
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<p>provider is not an OLP, they must be affiliated to a clinic, hospital or other agency <del>in order to</del> 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.</p>			
<p>Individual</p>		<p>Peer Support Specialist certified under NDAC 75-03-43</p>	<p>The individual providing the service must:</p> <ol style="list-style-type: none"> <li>1. Be employed by a ND Medicaid enrolled agency <del>provider of</del> <u>provider of</u> this service.</li> <li>2. Be at least 18 years of age.</li> <li>3. Be certified as a Peer Support Specialist I or II under NDAC 75-03-43</li> <li>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</li> </ol> <p><b>Supervision Requirements:</b>          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 <a href="#">NDDHHS Medical Services Division</a>.</p> <p>A Qualified Peer Supervisor must:</p> <ul style="list-style-type: none"> <li>• Be at least 18 years of age</li> <li>• Be a certified peer specialist II; OR             <ul style="list-style-type: none"> <li>• Have one of the following combinations:                 <ul style="list-style-type: none"> <li>▪ High school diploma or GED</li> </ul> </li> </ul> </li> </ul>



			and at least:
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			<ul style="list-style-type: none"> <li>• Be a North Dakota certified Peer Support Specialist I</li> <li>• Three years of work experience as a peer specialist or peer recovery coach including at least 2,250 hours of direct client service; or</li> <li>• 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</li> <li>• 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</li> <li>• Bachelor’s degree from an accredited college or university and at least two years of full-time work experience supervising others; or</li> <li>• Be the director of an organization providing peer support services; and</li> <li>• Have completed a state-approved peer support specialist supervision training.</li> </ul>
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**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
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North Dakota enrolled agency provider of 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.
<b>Service Delivery Method.</b> (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> X	<input type="checkbox"/> Provider managed

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):	
Service Title:	<b>Family Peer Support</b>
Service Definition (Scope):	
<p>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.</p> <p>A <u>participant's member's</u> 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.</p> <p>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.</p> <p>Services can be provided in any compliant community-based setting with the participant's primary care-giver present.</p> <p><b>Peer Support Services Include:</b>        Engagement and Bridging,</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Based on the strengths and needs of the youth and family, connecting them with appropriate services and supports. Accompanying the family when visiting programs.</li> <li>• Facilitating meetings between families and service providers.</li> <li>• Assisting the family to gather, organize and prepare documents needed for specific services.</li> <li>• Addressing any concrete or subjective barriers that may prevent full participation in services,</li> </ul>	

- 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, ~~expectation~~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, ~~service~~services, and supports and exploring what might be appropriate for their child and ~~family~~family.
  - Exploring the needs and preferences of the family and locating relevant resources.
  - Helping families understand eligibility ~~rules~~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~~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~~support, and create opportunities for ongoing natural support.
- Working collaboratively with schools to promote family engagement.

Agencies must have records available for [NDDHHS–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~~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-minute 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 [NDDHHS Medical Services Division or contracted MCO](#).

Services is limited to [individuals-families](#) with participants under the age of 18.

**The following activities are not reimbursable for [Medicaid](#) 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) [with the exception of except for](#) attending school meetings with the parent/caregiver on behalf of the child.
- ~~Child-care~~ [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 [an individual 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. [Individuals 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 [an individual a member](#) is enrolled in both the 1915(i) and a 1915(c) waiver and [is in need of needs](#) this 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 [contact the State Medicaid Office to inquire look in MMIS to see](#) if the member has any eligibility spans for any of the C waivers in MMIS. If yes, the Care Coordinator will reach out to the 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 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 [individual member](#)'s record and kept on file.

~~Family~~ Peer Support Specialist must meet in person with the participant before providing ~~telehealth~~ ~~remote services~~ and at least quarterly, after which ~~remote support~~ ~~telehealth~~ may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar ~~month.~~ ~~month.~~

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

~~Remote support~~ ~~Telehealth~~ options include:

- Telephone
- Secure Video Conferencing

~~Remote support~~ ~~Telehealth~~ must:

- be elected by the [individual 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 ~~remote support~~ ~~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 member](#) into the community.

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

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services ~~in an effort to~~ ~~to~~ hide their conditions from others. ~~Remote support~~ ~~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. ~~Remote support~~ ~~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 ~~in the midst of~~ ~~a crisis situation~~ ~~a crisis~~ or addiction relapse will be

able to more



<p>easily reach out to 1915(i) service providers, reducing risks associated with their conditions and the likelihood of needing a higher level of care.</p> <p>Agencies must have records available for <del>NDDHHS—Medical Services Division</del> review documenting that individual providers have knowledge of and competency in the following:</p> <ul style="list-style-type: none"> <li>• Person-Centered Plan Implementation</li> </ul>			
<p>x Medically needy (<i>specify limits</i>):</p> <p>Same limits as those for categorically needy.</p>			
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> )	Certification ( <i>Specify</i> )	Other Standard ( <i>Specify</i> ):
<p>North Dakota Medicaid Enrolled Agency provider of Family Peer Support</p> <p><del>NDDHHS Medical Services Division</del> defines billing group provider as an individual or entity that <del>is-able to can</del> 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 <del>, and others-</del></p>	None	None	<p>An enrolled agency provider of this service must meet <del>all of all</del> the following criteria to enroll as a provider:</p> <p>Have a North Dakota Medicaid provider agreement and attest to the following:</p> <ul style="list-style-type: none"> <li>• individual practitioners meet the required qualifications</li> <li>• services will be provided within their scope of practice</li> <li>• individual practitioners will have the required competencies identified in the service scope</li> <li>• agency conducts training in accordance with state policies and procedures</li> <li>• 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 <del>NDDHHS—Medical Services Division</del> review upon request.</li> </ul> <p><del>3-</del></p>

<del>are not.</del> Examples			
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<p><del>of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity. Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other licensed practitioners'.</del> <u>Licensed practitioners</u> (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</p>			
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enroll as their own billing			
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<p>group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency <del>in order to</del> 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.</p>			
<p>Individual</p>		<p>Peer Support Specialist certified under NDAC 75-03-43</p>	<p>The individual providing the service must:</p> <ul style="list-style-type: none"> <li>• Be employed by a <u>ND</u> Medicaid enrolled provider of this service.</li> <li>• Be at least 18 years of age</li> <li>• Be certified as a Peer Support Specialist I or II under NDAC 75-03-43.</li> <li>• 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</li> </ul> <p><b>Supervision Requirements:</b>      For every 30 hours of <u>Family</u> 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 <u>NDDHHS Medical Services Division</u>.      A Qualified Peer Supervisor must:</p> <ul style="list-style-type: none"> <li>• Be at least 18 years of age;</li> <li>• Be a certified peer specialist II; or</li> </ul>

			<ul style="list-style-type: none"><li>• Have one of the following combinations:<ul style="list-style-type: none"><li>▪ High school diploma or GED and at least:<ul style="list-style-type: none"><li>• Be a North Dakota Certified Peer Support Specialist I</li><li>• Three years of work experience as a peer specialist or peer recovery coach including at least 2,250 hours of direct client service; or</li><li>• 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</li><li>• 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 1,500 hours of direct client service; or</li><li>• Bachelor's degree from an accredited college or university and at least two years of full-time work experience supervising others; or</li><li>• Be the director of an organization providing peer support services; and</li></ul></li></ul></li><li>• Have completed a state approved peer support specialist supervision training</li></ul>
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Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
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.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="radio"/> Participant-directed	<input checked="" type="radio"/> Provider managed	

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	<b>Respite Care</b>
Service Definition (Scope):	
<p>Respite Care is a service provided to a <del>member</del><del>participant</del> unable to care for <del>himself/herself</del><del>themselves</del>. 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.</p> <p>Respite services are available to <del>participants</del><del>members</del> receiving the HCBS benefit who are residing in <del>his or her</del><del>their</del> family home (biological or kin), legal guardian’s home, pre-adoptive/adoptive, or foster home.</p> <p>Routine respite care may include hourly, <del>daily</del><del>daily</del>, and overnight support.</p> <p>A <del>member</del><del>participant</del>’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 <del>participant’s</del> <del>member’s</del> identified goals in the Person-Centered POC and document the <del>participant’s</del> <del>member’s</del> progress toward their goals.</p> <p>Agencies must have records available for <del>NDDHHS</del><del>Medical Services Division</del> review documenting that individual providers have knowledge of and competency in the following:</p> <ul style="list-style-type: none"> <li>○ Person-Centered Plan Implementation</li> </ul> <p>Persons and agencies providing respite services must comply with all state and federal respite standards. Approved 1915(i) service providers may also include:</p>	

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

Respite Care may be provided in the ~~participant's 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 ~~the~~ NDDHHS.

Respite Care service activities include:

- 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

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~~~~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*):

This service is reimbursed as a ~~15-minute~~ 15-minute unit rate. Maximum number of hours a ~~member~~ participant is 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 ~~NDDHHS~~ 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 services do not include on-going day care or before or after school programs. Respite services are 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 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 to receive respite services 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 ~~he/she/they~~ receives 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 ~~an individual~~ 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. Individual 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 an individual member is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of needs~~ this service which is offered in both, the individual 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~~s~~; 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 ~~contact the State Medicaid Office to inquire~~ look up the member in MMIS to see if the member has any eligibility spans for any of the C waivers in MMIS. If yes, the Care Coordinator will reach out to the 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 ~~a~~Agency. Justification that services are not otherwise available to the individual 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 individual member’s record and kept on file.

This service is available to individual members ~~a~~ Age 0 to ~~Age 2020 and not available to individuals Age 21 and older.~~

~~Respite care shall not be used as day/childcare to allow the caregiver to go to work or school.~~

Respite services 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.

<del>Respite care cannot be used to provide service to a participant while the participant is eligible to receive Part B services and could otherwise gain support through the NDDHHS of Public Instruction.</del>			
<input checked="" type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
Same limits as those for categorically needy.			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
North Dakota Medicaid enrolled agency provider of Respite  <u>NDDHHS Medical Services Division</u> 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 <del>all of</del> the following criteria: Have a North Dakota Medicaid provider agreement and attest to the following: <ul style="list-style-type: none"> <li>• individual practitioners meet the required qualifications</li> <li>• services will be provided within their scope of practice</li> <li>• individual practitioners will have the required competencies identified in the service scope</li> <li>• agency conducts training in accordance with state policies and procedures</li> <li>• 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 rewritten and available for <u>NDDHHS—Medical Services Division</u> review upon request.</li> </ul>

<del>others are</del>			
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<del>affiliated to a clinic, hospital, or other entity:- Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other 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</del>	<p>Child Care Centers licensed under NDAC 75-03-10;</p> <p>Providers licensed by the NDDHHS, Division of Developmental Disabilities under NDAC 75-04-01;</p> <p>Qualified Residential Treatment Program Providers licensed by the NDDHHS, Children and Family Services Division, under 75-03-40 and enrolled as a 1915i Medicaid Provider;</p> <p>Psychiatric Residential Treatment Facility Providers licensed by the NDHHS, Behavioral Health Division, under NDAC 75-03-17 and enrolled as a 1915(i) Medicaid</p>		
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<p>own billing group provider if</p>	<p>Provider;</p>		
<p>they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency <del>in order to</del> enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the <del>provider</del> providers are listed under each service.</p>	<p>Providers licensed by the NDDHHS under 75-05-00.1 Human Service Center Licensure Substance Abuse Treatment Program licensed under NDAC 75-09.1</p>		

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  2)3) <u>Be knowledgeable and competent in person-centered plan implementation</u>
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>		<b>Frequency of Verification</b> <i>(Specify):</i>
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 their enrollments at least once every five (5) years.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i> ):	
Service Title:	<b>Non-Medical Transportation (NMT)</b>
<b>Service Definition (Scope):</b>	
<p>This service is offered <del>in order to</del> enable 1915(i) <del>participants</del> <del>members</del> to gain access to 1915(i) and other community services, <del>activities</del> <del>activities</del>, and resources, as specified by the person-centered plan of care. NMT increases the <del>participant's</del> <del>member's</del> 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, <del>cost-effective</del> <del>cost-effective</del> mode available. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.</p> <p>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 <del>participant</del> <del>member's</del> needs as determined by an assessment. Services are available for <del>participants</del> <del>members</del> to access authorized HCBS and destinations that are related to a goal included on the <del>participant's</del> <del>member's</del> 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.</p> <p>A <del>participant's</del> <del>member's</del> 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 <del>participant's</del> <del>member's</del> identified goals in the Person-Centered POC and document the <del>participant's</del> <del>member's</del> progress toward their goals.</p>	
Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):	
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, <del>duration</del> <del>duration</del> , 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.	
<i>(Choose each that applies):</i>	
<input checked="" type="checkbox"/> Categorically needy ( <i>specify limits</i> ):	
<p>NMT will only be available for non-routine, time-limited services, not for ongoing treatment or services or for routine transportation to and from a job or school.</p> <p>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.</p> <p>A NMT provider must be enrolled in the ND Medicaid program and meet all applicable motor vehicle and licensing requirements.</p>	

<p>NMT is solely for transporting the <del>client-member</del> to and from <del>his/her/their</del> home to essential services as allowed within the scope of the service. It does not include the cost of staff transportation to or from the <del>client's-member's</del> home.</p> <p>Individuals receiving Non-Medical Transportation <del>s</del>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).</p> <p>This service cannot be provided to <del>an individual a member</del> 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. <del>IndividualMembers</del> 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 <del>an individual a member</del> is enrolled in both the 1915(i) and a 1915(c) waiver and <del>is in need of needs</del> this service which is offered in both, the <del>individual member</del> is required to access the service through the 1915(c) rather than the 1915(i).</p> <p>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.</p> <p style="padding-left: 40px;">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 <del>contact the State Medicaid Office to inquire</del> <del>look at MMIS to see</del> if the member has any eligibility spans for any of the C waivers in MMIS. If yes, the Care Coordinator will reach out to the C Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.</p> <p>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 <del>individual member</del> 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 <del>individual member's</del> record and kept on file.</p> <p>Agencies must have records available for <del>NDDHHS Medical Services Division or contracted MCO</del> review documenting that individual providers have knowledge of and competency in the following:</p> <ul style="list-style-type: none"> <li>○ Person-Centered Plan Implementation</li> </ul>			
<p><input checked="" type="checkbox"/> Medically needy (<i>specify limits</i>):</p>			
<p>Same limits as those for categorically needy.</p>			
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>			
<p>Provider Type (<i>Specify</i>):</p>	<p>License (<i>Specify</i>):</p>	<p>Certification # (<i>Specify</i>):</p>	<p>Other Standard (<i>Specify</i>):</p>

<p>Medicaid Enrolled agency provider of Non-Medical Transportation Provider</p> <p><u>NDDHHS Medical Services Division</u> defines billing group provider as an individual or entity that <del>is able to</del> <u>can</u> 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, <del>and others are not.</del> <u>Examples of</u></p>	<p>NDCC Title 39-06 Motor Vehicles and Operating License</p>	<p>None</p>	<p>A provider of this service must meet <del>all of</del> the following criteria:</p> <p><del>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.</del></p> <p><del>1. Have a North Dakota Medicaid provider agreement and attest to the following:</del></p> <ul style="list-style-type: none"> <li><del>• individual practitioners meet the required qualifications</del></li> <li><del>• services will be provided within their scope of practice</del></li> <li><del>• individual practitioners will have the required competencies identified in the service scope</del></li> <li><del>• agency conducts training in accordance with state policies and procedures</del></li> <li><del>•</del></li> <li><del>• 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 NDDHHS Medical Services Division review upon request</del></li> <li><del>• Agency adheres to ND State Laws regarding motor vehicles, operating licenses and insurance, and uses licensed public transportation carriers</del></li> </ul> <p>The individual providing the service must:</p> <ol style="list-style-type: none"> <li>1) Be employed by an enrolled ND Medicaid enrolled billing group of this service.</li> <li>2) Be at least 18 years of age</li> <li>3) Have a valid government issued driver's license</li> </ol>
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<p><del>practitioners that could enroll independent ly without being affiliated to a clinic, hospital, or other entity:</del> <del>Licensed Professional Clinical Counselor,</del> <del>Licensed Clinical Social Worker,</del> <del>Licensed Marriage and Family Therapist,</del> <del>Psychologist</del> <del>, Nurse Practitioner and Physician.</del> These practitioners are considered <del>other</del> Licensed practitioners <sup>2</sup> (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</p>			
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<p>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 <del>in order to</del> 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.</p>			
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<p>Provider Type <i>(Specify):</i></p>	<p>Entity Responsible for Verification <i>(Specify):</i></p>	<p>Frequency of Verification <i>(Specify):</i></p>	
<p>Enrolled Medicaid agency provider of Non- Medical Transportation</p>	<p>North Dakota Medical Services Provider Enrollment</p>	<p>Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation.</p> <p>Providers are required to revalidate their enrollments at least once every five (5) years.</p>	
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed		

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

Service Title:	<b>Community Transition Services (CTS)</b>
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**Service Definition (Scope):**

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a NF, ICF, ~~IMD~~, or PRTF to a living arrangement in a private residence where the person is directly responsible ~~for his or her~~for their own living expenses.

Community Transition Services may be authorized up to 90 consecutive days prior to the individual being determined eligible for the 1915(i) and 90 days from the date the individual became eligible for the 1915(i).

**To be eligible for this service all the following must be present:**

- Individual is currently residing in ~~a ND Medicaid Institution~~an institutional setting;
- Individual has resided in the ~~ND Medicaid Institution~~institutional setting for a minimum of 30 consecutive days, and is transferring from a NF/ID/~~ICF/IMD~~/PRTF (Psychiatric Residential Treatment Facility)
- An anticipated discharge date has been established;
- The individual will be discharged to a living arrangement in a private residence ~~where he/she is~~where they are directly responsible for ~~his or her~~their own living expenses;
- Individual will be receiving Medicaid or Medicaid Expansion upon discharge from the institution;
- Individual will have a federal poverty level of 150% or below upon discharge from the institution;
- Individual has a qualifying 1915(i) diagnosis;
- Individual has a WHODAS complex score of 25 or higher or a score of 5 or lower on the DLA; and
- Individual is reasonably expected to be eligible for and enroll in the 1915(i) within 90 days of the approval of the community transition service.

The case manager responsible for coordinating the individual's discharge planning must request and receive approval for the service from the ~~State Medicaid office~~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 required to 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 determined 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 Transition 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 ~~Medicaid institution~~. The costs of such services are incurred and billable when the person leaves the institutional setting and enters ~~the~~ 1915(i). The individual must be reasonably expected to be eligible for and to enroll in ~~the~~ 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*):

	<p>See the current fee schedule <del>on the department's website</del> for the maximum allowable budget per lifetime to be utilized within the 180 consecutive day window.</p> <p>This service cannot be provided to an <del>individual member</del> 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. <del>IndividualMembers</del> 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 an <del>individual member</del> is enrolled in both the 1915(i) and a 1915(c) waiver and <del>is in need of needs</del> this service which is offered in both, the <del>individual member</del> is required to access the service through the 1915(c) rather than the 1915(i).</p> <p>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. <del>IndividualMembers</del> 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).</p> <p style="padding-left: 40px;">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 <del>contact the State Medicaid Office to inquire</del> <del>review MMIS to see</del> if the member has any eligibility spans for any of the C waivers in MMIS. If yes, the <del>State Medicaid Office</del> <del>Medical Services Division</del> will determine if the member has accessed Community Transition Services in the <del>past, and past and</del> will not approve the request if prior access is confirmed.</p> <p>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 <del>individual member</del> 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 <del>individual member's</del> record and kept on file.</p>		
○			
X	<p>Medically needy (<i>specify limits</i>):</p> <p>Same limits as those for categorically needy.</p>		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):

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.
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<p><u>NDDHHS Medical Services Division</u> 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, <del>and others are not.</del> Examples of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical</p>			
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<p><del>Social- Worker,- Licensed- Marriage- and Family- Therapist,- Psychologist ,-Nurse- Practitioner- and- Physician.- These- practitioners are- considered- 'other- 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 <del>in order to</del> enroll. Each</del></p>			
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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.			
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**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):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

Service Title:	<b>Benefits Planning Services</b>
Service Definition (Scope):	
Benefits Planning Services offer <del>individualmembers</del> in-depth guidance about public benefits, including Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid etc. Services are available to <del>individualmembers</del> considering or seeking competitive employment and can assist <del>individualmembers</del> with making informed choices regarding public benefits and provide an understanding of available work incentives.	
Benefits Planning services include:	
<ul style="list-style-type: none"> <li>Development of an individualized assessment, and benefits analysis. Plan must identify</li> </ul>	

the ~~individualmember~~'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 ~~individualmember~~ with managing changes in their benefits, the work incentives they use, negotiating with SSA, and other benefit program administrators.

A ~~participant's-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 member's~~ identified goals in the Person-Centered POC and document the ~~participant's-member's~~ progress toward their goals.

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

X Categorically needy (*specify limits*):

Benefits Counseling 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 [NDDHHS Medical Services Division or contracted MCO](#).

This service cannot be provided to ~~an individuala 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. ~~IndividualMembers~~ 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 ~~an individuala member~~ is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of needs~~ this service which is offered in both, the ~~individualmember~~ 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 ~~contact the State Medicaid Office~~

[look in MMIS to see if the member](#)



~~inquire if the member~~ has any eligibility spans for any of the C waivers in MMIS. If yes, the Care Coordinator will reach out to the 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 ~~individualmember~~ 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 ~~individualmember~~'s record and kept on file.

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

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

~~Remote supportTelehealth~~ options include:

- Telephone
- Secure Video Conferencing

~~Remote supportTelehealth~~ must:

- be elected by the ~~individualmember~~ 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 ~~remote supporttelehealth~~ 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 ~~individualmember~~ into the community.

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

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services ~~in an effort to~~ hide their conditions from others. ~~Remote supportTelehealth~~ 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. ~~Remote supportTelehealth~~ alternatives will make ongoing

care and follow- ups more convenient and easier to schedule for the member, likely increasing the

<p>number of appointments made, as well as the number of appointments kept.</p> <ul style="list-style-type: none"> <li>Members <del>in the midst of a mid a crisis situation</del> <u>a crisis</u> 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.</li> </ul> <p>Limitations applicable to <del>remote support</del> <u>telehealth</u> service delivery of services:</p> <ul style="list-style-type: none"> <li><del>Remote support</del> <u>Telehealth</u> cannot be used for more than 25% of all benefits planning services in a calendar month.</li> </ul>			
<p>X Medically needy (<i>specify limits</i>):</p>			
<p>Same limits as those for categorically needy.</p>			
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
<p>North Dakota Medicaid enrolled agency provider of Benefits Planning Services</p> <p><del>NDDHHS Medical Services Division</del> defines billing group provider as an individual or entity that <del>is able to</del> <u>can</u> enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll</p>			<p>A provider of this service must meet <del>all of all</del> the following criteria:</p> <p>1. Have a North Dakota Medicaid provider agreement and attest to the following:</p> <ul style="list-style-type: none"> <li>individual practitioners meet the required qualifications</li> <li>services will be provided within their scope of practice</li> <li>individual practitioners will have the required competencies identified in the service scope</li> <li>agency conducts training in accordance with state policies and procedures</li> <li>agency adheres to all 1915(i) standards and requirements</li> <li>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 <del>NDDHHS Medical Services Division</del> review upon request.</li> </ul>

independent ly			
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<p><del>ly without being affiliated to a clinic, hospital or other agency. <sup>1</sup> and others are not. Examples of practitioners that could enroll independent ly without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered <sup>2</sup> other Licensed practitioners <sup>2</sup> (OLP) in the ND Medicaid State Plan</del></p>			
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<p>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, <del>hospital</del> hospital, or other agency <del>in order to</del> 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.</p>			
<p>Individual</p>		<p>Certified Work Incentives Counselor (CWIC) or Community Partner Work Incentives Counselor (CPWIC) or SSI/SSDI Outreach Access and Recovery (SOAR).</p>	<p>The individual providing the service must:</p> <ol style="list-style-type: none"> <li>1) <del>1)</del> <u>Be at least 18 years of age</u></li> <li>2) <u>Be employed by an enrolled ND Medicaid enrolled billing group of this service.</u></li> <li><del>3)</del> <u>3) Have knowledge and competency in person-centered plan implementation</u></li> </ol>

<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
<u>NDDHHS Medical Services Division</u> 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.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed <input checked="" type="checkbox"/> Provider managed		

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	<b>Prevocational Training</b>
Service Definition (Scope):	
<p>Pre-vocational services are time-limited community-based services that prepare <a href="#">an individual member</a> for employment or volunteer work. This service specifically provides learning and work experiences where the <a href="#">individual member</a> can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings.</p> <p>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 <a href="#">individual member's</a> 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</p>	

individualmember 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 individualmember'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 individualmembers 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 individualmember'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

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 [individualmembers](#) 6 months before their 18<sup>th</sup> birthday 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 [unitrateunit](#) ~~rt~~

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 [NDDHHSMedical Services Division or contracted MCO](#).

[IndividualMember](#)s receiving Pre-Vocational services through the HCBS DD Waiver cannot receive this service through the 1915(i).

This service cannot be provided to [an individuala 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. [IndividualMembers](#) 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 [an individuala member](#) is enrolled in both the 1915(i) and a 1915(c) waiver and [is in need ofneeds](#) this service, which is offered in both, the [individualmember](#) is required to access the service through the 1915(c) rather than the 1915(i). The state has identified the Pre-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 C waivers in MMIS. If yes, the Care Coordinator will reach out to the 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 [individualmember](#) 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 [individualmember](#)'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

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

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

~~Remote support~~ Telehealth options include:

- Telephone
- Secure Video Conferencing

~~Remote support~~ Telehealth must:

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

For each utilization, providers must document that the ~~remote support~~ 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 member into the community.

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

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services ~~in an effort to~~ hide their conditions from others. ~~Remote support~~ 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. ~~Remote support~~ 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 ~~in the midst of~~ 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 ~~NDDHHS 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 ( <i>specify limits</i> ):			
Same limits as those for categorically needy.			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> )	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):

<p>North Dakota Medicaid enrolled agency provider of Vocational Training</p> <p><del>NDDHHS Medical Service Division</del> define billing group provider as an individual or entity that <del>is able to</del> enroll to provide 1915(i) services. Depending on their licensure or certification, certain practitioners are allowed to enroll <del>independently</del> <del>independently</del> without being affiliated</p>	<p>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</p>		<p>A provider of this service must meet <del>all of</del> the following criteria:        Have a North Dakota Medicaid provider agreement and attest to the following:</p> <ul style="list-style-type: none"> <li>• individual practitioners meet the required qualifications</li> <li>• services will be provided within their scope of practice</li> <li>• individual practitioners will have the required competencies identified in the service scope</li> <li>• agency conducts training in accordance with state policies and procedures</li> <li>• 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 <del>NDDHHS Medical Services Division</del> review upon request.</li> <li>• 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</li> </ul>
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<p>to a clinic, hospital or other agency <del>and others are not.</del> Examples of practitioner s that could enroll <del>independen</del> <del>t</del> <del>independe</del> <del>ntly</del> without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioner s are considered <del>other</del> Licensed practitioner s <del>practitione</del> <del>rs</del>' (OLP) in the ND</p>	<p>individual requirements.</p>		
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<p>Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioner sare allowed to enroll as their own billing group provider if they choose.If a provideris not an OLP, they must be affiliated to a clinic, hospital or other agency<del>in</del> <del>order to</del> enroll. Each billing group provider must meet the qualificatio ns specified in the 1915(i) stateplan pages. The minimum qualificatio ns for the provider are listed under each service.</p>			
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Individuals		<p>Must have one of the following certifications:</p> <ul style="list-style-type: none"> <li>- Employment Specialist;</li> <li>- Brain Injury Specialist;</li> <li>- Direct Support Provider (DSP);</li> <li>- Career Development Facilitation</li> </ul>	<p>The individual providing the service must:</p> <ol style="list-style-type: none"> <li>1) Be employed by an enrolled ND Medicaid enrolled billing group of this service; and</li> <li>2) Be at least 18 years of age; and</li> <li>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</li> <li>4) Have a High School Diploma or GED.</li> </ol> <p>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.</p> <p>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 <del>forementioned licensure</del> <u>licensure</u> or accreditation requirements.</p> <p>Supervisors of Individual Providers must meet the Individual Provider requirements and have two or more years of experience working in a vocational setting.</p>
<p><b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):</p>			
<p>Provider Type (Specify):</p>	<p>Entity Responsible for Verification (Specify):</p>	<p>Frequency of Verification (Specify):</p>	
<p>North Dakota Medicaid enrolled agency provider of Prevocational Training Services</p>	<p>North Dakota Medicaid Provider Enrollment</p>	<p>Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation.</p> <p>Providers are required to revalidate their enrollments at least once every five (5) years.</p>	
<p><b>Service Delivery Method.</b> (Check each that applies):</p>			
<p><input type="checkbox"/> Participant-directed</p>	<p><input checked="" type="checkbox"/></p>	<p><input type="checkbox"/> Provider managed</p>	

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	<b>Supported Education</b>
Service Definition (Scope):	
<p>Supported Education Services (<del>SEd</del>)—are individualized and promote engagement, sustain participation and restore an <del>individual's</del> <del>member's</del> ability to function in the learning environment. Services must be specified in the person-centered plan of care to enable the <del>individual</del> <del>member</del> to integrate more fully into the community and/or educational setting and must ensure the health, welfare, and safety of the <del>individual</del> <del>member</del>. The goals of <del>Supported Education</del> <del>Ed</del> are for <del>individual</del> <del>members</del> 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.</p> <p>A <del>participant's</del> <del>member's</del> 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 <del>participant's</del> <del>member's</del> identified goals in the Person-Centered POC and document the <del>participant's</del> <del>member's</del> progress toward their goals.</p> <p>Supported Education Services (<del>SEd</del>) 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 <del>individual's</del> <del>member's</del> 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 <del>individual</del> <del>member</del> through these agencies undersection 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the <del>individual</del> <del>member's</del> record and kept on file.</p>	
Supported Education services may include, but are not limited to, any combination of the following:	
<p><b>Engage, bridge and transition</b></p> <ul style="list-style-type: none"> <li>• Act as a liaison/support in the educational learning environment.</li> <li>• Facilitate outreach and coordination.</li> <li>• Familiarize individual and caregiver (if applicable) to school settings, to help navigate the school system and student services.</li> <li>• Assist with admission applications and registration.</li> <li>• Assist with transitions and/or withdrawals from programs such as those resulting from behavioral health challenges, medical conditions, and other co-occurring disorders.</li> </ul>	

- Improve access by effectively linking [consumers-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 [individualmembers'](#) 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 [individualmembers](#) 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 process to 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 breaks during 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.	
<ul style="list-style-type: none"><li>• Identify financial aid resources and assist with applications for <a href="#">F</a>inancial <a href="#">a</a>id.</li><li>• Assist in applying for student loan forgiveness on previous loans because of disability status.</li></ul>	
Ongoing supported education service components are conducted after an <a href="#">individual member</a> is successfully admitted to an educational program.	
Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):	
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):	
<input checked="" type="checkbox"/>	Categorically needy ( <i>specify limits</i> ):
This service is available to individuals <a href="#">a</a> ges 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 ~~North Dakota Department of Human Services~~ ~~Division of Medical Services~~ ~~Division~~ or contracted MCO.

This service cannot be provided to an ~~individual 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. ~~Individual 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 an ~~individual member~~ is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of needs~~ this 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 ~~contact the State Medicaid Office to inquire~~ ~~look in MMIS to see e~~ if the member has any eligibility spans for any of the C waivers ~~in MMIS~~. If yes, the Care Coordinator will reach out to the 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 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 ~~individual member's~~ record and kept on file.

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

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

~~Remote support~~ ~~Telehealth~~ options include:

- Telephone
- Secure Video Conferencing

~~Remote support~~ ~~Telehealth~~ must:

- be elected by the ~~individual 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 ~~remote support~~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~~member into the community.

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

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services ~~in an effort to~~ hide their conditions from others. ~~Remote support~~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. ~~Remote support~~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 ~~in the midst of~~amid a crisis situationa 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 ~~NDDHHS~~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 ( <i>specify limits</i> ):		
Same limits as those for categorically needy.			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):

<p>North Dakota Medicaid enrolled agency provider of Supported Education</p> <p><u><a href="#">NDDHHS Medical Services Division</a></u> defines billing group providers 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, <del>and others are not. Examples of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical</del></p>	<p>Group Providers must: Be licensed under NDAC 75-04-01; <u>or</u> have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) <u>or</u> Council on Accreditation (COA) <u>or</u> 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.</p> <p>Licensing or Accreditation requirements do not apply to North Dakota Schools</p>	<p>None</p>	<p>A provider of this service must meet <del>all of all</del> the following criteria:</p> <p>Have a North Dakota Medicaid provider agreement and attest to the following:</p> <ul style="list-style-type: none"> <li>individual practitioners meet the required qualifications</li> <li>services will be provided within their scope of practice</li> <li>individual practitioners will have the required competencies identified in the service scope</li> <li>agency conducts training in accordance with state policies and procedures</li> <li>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 <u><a href="#">NDDHHS—Medical Services Division</a></u> review upon request.</li> <li>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</li> </ul>
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<p><del>Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other Licensed practitioners'</del><sup>2</sup> (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 <u>in order to</u> enroll. Each billing group provider must meet the qualifications</p>	<p>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.</p>		
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<p>specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.</p>			
<p>Individual</p>		<p>Must have one of the following certifications:</p> <ul style="list-style-type: none"> <li>- Employment Specialist or</li> <li>- Brain Injury Specialist or</li> <li>- Direct Support Provider (DSP)</li> </ul>	<p>The individual providing the service must:</p> <ul style="list-style-type: none"> <li>• Be employed by an enrolled ND Medicaid enrolled billing group of this service; and</li> <li>• Be at least 18 years of age; and</li> <li>• 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</li> <li>• Have a High School Diploma or GED.</li> </ul> <p>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.</p> <p>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 <del>aforementioned</del> <del>licensure</del> <del>licensure</del> or accreditation requirements.</p> <p>Supervisors of Individual Providers must meet the Individual Provider requirements and have two or more years of experience working in an educational setting.</p>
<p><b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):</p>			

Provider Type	Entity Responsible for Verification	Frequency of Verification
<i>(Specify):</i>	<i>(Specify):</i>	<i>(Specify):</i>
North Dakota Medicaid enrolled agency provider of Supported Education	North Dakota Medicaid Provider Enrollment	<p>Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation.</p> <p>Providers are required to revalidate their enrollments at least once every five (5) years.</p>
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
Participant-directed	X	Provider managed
<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>		
Service Title:	<b>Supported Employment</b>	
Service Definition (Scope):		
<p>Supported Employment (<del>SEP</del>) services assist <a href="#">individualmembers</a> to obtain and keep competitive employment at or above the minimum wage. After intensive engagement, ongoing follow-along support is available for an indefinite period as needed by the <a href="#">individualmember</a> to maintain their paid competitive employment position. <del>Supported EmploymentEP</del> services are individualized, person-centered services providing supports to <a href="#">individualmembers</a> who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.</p> <p><del>Supported EmploymentEP</del> services can be provided through many different service models. Some of these models can include evidence-based supported employment, or customized employment for <a href="#">individualmembers</a> with significant disabilities. <del>SE Supported Employment</del> 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.</p> <p>A <del>participant's member's</del> 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</p>		
<p>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 <del>participant's member's</del> identified goals in the Person-Centered POC and document the <del>participant's member's</del> progress toward their goals.</p> <p>Supported Employment services may be furnished to any <a href="#">individualmember</a> that elects to receive <del>support, and support and</del> demonstrates a need for the service. Services are authorized during the person-centered planning process by the Care Coordinator to assist the <a href="#">individualmember</a> with achieving goals identified in the person-centered plan of care. Services must be provided in a manner which honors the <a href="#">individualmember's</a> preferences (scheduling, choice of provider, direction of work), and consideration for common courtesies such as timeliness and reliability.</p>		

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 individual member through these ~~agencies~~ 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 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 skill training that enable the participant to be successful in integrating into the job setting.

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

Ongoing Follow-Along Support services are available to ~~an individual~~ 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, 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 ~~individual~~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) ~~is~~. 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 ~~North Dakota Department of Health and Human Services~~Medical Services Division or contracted MCO.

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

This service cannot be provided to an ~~individual~~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. ~~Individual~~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 an ~~individual~~member is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of~~needs this service which is offered in both, the ~~individual~~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 ~~contact the State Medicaid Office to inquire~~check MMIS to see if the member has any eligibility spans for any of the C waivers in MMIS. If yes, the Care Coordinator will reach out to the C Waiver authority and do due diligence to ensure the plan of care does not include duplicative services.

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

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

~~Remote support~~Telehealth options include:

- Telephone
- Secure Video Conferencing

~~Remote support~~Telehealth must:

- be elected by the ~~individual~~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 ~~remote support~~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~~member into the community.

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

- Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services ~~in an effort to~~ hide their conditions from others. ~~Remote support~~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. ~~Remote support~~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 ~~in the midst of~~amid a crisis situation 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.

Federal

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: <ul style="list-style-type: none"> <li>• Incentive payments made to an employer to encourage or subsidize the employer’s participation in supported employment; or</li> <li>• Payments that are passed through to users of employment services.</li> </ul>			
Agencies must have records available for <a href="#">NDDHHS-Medical Services Division or contracted MCO</a> review documenting that individual providers have knowledge of and competency in the following: <ul style="list-style-type: none"> <li>○ Person-Centered Plan Implementation</li> </ul>			
Medically needy ( <i>specify limits</i> ):			
Same limits as those for categorically needy.			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> )

<p>North Dakota Medicaid enrolled agency provider of Supported Employment <u>NDDHHS Medical Services Division</u> defines billing group provider as an individual or entity that <del>is able to</del> 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,</p>	<p>Group Providers must: Be licensed under NDAC 75-04-01; <u>or</u> have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) <u>or</u> Council on Accreditation (COA) <u>or</u> The Council on Quality Leadership (CQL) <del>Accreditation;</del> <u>Accreditation;</u> <u>or</u> 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.</p>		<p>A provider of this service must meet <del>all of</del> the following criteria:</p> <p>Have a North Dakota Medicaid provider agreement and attest to the following:</p> <ul style="list-style-type: none"> <li>• individual practitioners meet the required qualifications</li> <li>• services will be provided within their scope of practice</li> <li>• individual practitioners will have the required competencies identified in <del>the service</del> <u>the scope</u></li> <li>• agency conducts training in accordance with state policies and procedures</li> <li>• 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 <u>NDDHHS Medical Services Division</u> review.</li> <li>• 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.</li> </ul>
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<p>hospital or <del>other</del> <u>another</u> agency, <del>and others are not.</del> <u>Examples of practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered <del>other</del> <u>Licensed practitioners</u> (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan</u></p>	<p>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.</p>		
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<p>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 <del>in</del> 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.</p>			
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<p>Individuals</p>		<p>Must have one of the following certifications:          -Employment Specialist <u>or</u>          -Brain Injury Specialist <u>or</u>          -          -Direct Support Provider (DSP)<u>or</u>          -Career Development Facilitation</p>	<p>The individual providing the service must:</p> <ul style="list-style-type: none"> <li>• Be employed by an enrolled ND Medicaidenrolled billing group of this service; and</li> <li>• Be at least 18 years of age; and</li> <li>• 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</li> <li>• Have a High School Diploma or GED.</li> </ul> <p>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.</p> <p>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 <b>aforementioned lieensurelicensure</b> or accreditation requirements.</p> <p>Supervisors of Individual Providers must meet the Individual Provider requirements and have two or more years of experience working in an educational setting.</p>
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**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	<i>North Dakota Medicaid Provider Enrollment</i>	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):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

Service Title:	<b>Housing Support</b>
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Service Definition (Scope):

Housing Supports help ~~individual~~~~member~~'s<sup>2</sup> 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 models may include Permanent Support Housing (PSH) for ~~individual~~~~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 ~~individual~~~~member~~ with stabilizing and accessing to the greater community.

A ~~member~~~~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~~~~member's~~ identified goals in the Person-Centered POC and document the ~~participant's~~~~member's~~ progress toward their goals.

**Pre-Tenancy** services provide ~~individual~~~~members~~ the support that is needed to secure housing. Pre-tenancy services are available only to the ~~individual~~~~member~~ living in the community and may not be billed when a ~~individual~~~~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: (e.g., housing assistance, SSI, SSDI, TANF, SNAP, LIHEAP, etc.)~~.
- Assisting with the housing search process and identifying and securing housing of ~~the member's choice~~ ~~their 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 [individual 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-centered plan.
- Providing training and education on the roles, rights, and responsibilities of the tenant and the landlord.
- Coaching on how to develop and maintain relationships with landlords and property managers.
- 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 risk of 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 [individual member](#)'s home.
- Coordinating and linking [individual members](#) to services and service providers in the community that would assist a [individual 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 [individual members](#) receiving services and supports.

Services are available to [individual members](#) six months prior to their 18<sup>th</sup> birthday.

[Individual Members](#) eligible to receive 1915(i) state plan amendment services may elect to receive housing support services if the [individual 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 that complies 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 an ~~individual~~ ~~member~~'s rights or privacy, dignity and respect, and freedom from coercion and restraint; optimize individual initiative, ~~autonomy~~ ~~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 ~~authorized~~ ~~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 ~~NDDHHS~~ [Division of 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.

~~Collateral contacts are allowed with landlords, potential landlords, or other housing programs that are directly related to assisting the member in obtaining housing.~~

This service cannot be provided to an ~~an~~ [individual 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. [Individual 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 ~~ana~~ [individual member](#) is enrolled in both the 1915(i) and a 1915(c) waiver and ~~is in need of~~ [needs](#) this service which is offered in both, the [individual 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 ~~contact the State Medicaid Office~~ [look at MMIS](#) to inquire if the member has any eligibility spans for any of the C waivers in MMIS. If yes, the Care Coordinator will reach out to the 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 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 [individual member](#)'s record and kept on file.

~~Remote support~~ [Telehealth](#) may be utilized, however in-person support must be provided for a minimum of 25% of all services provided in a calendar ~~month.~~ [month.](#)

	<p><del>Remote support</del> <u>Telehealth</u> includes real-time, two-way communication between the service provider and the participant. <del>Remote support</del> <u>Telehealth</u> is limited to check-ins (e.g., reminders, verbal cues, prompts) and consultations (e.g., counseling, problem solving) within the scope of services.</p> <p><del>Remote support</del> <u>Telehealth</u> options include:</p> <ul style="list-style-type: none"> <li>• Telephone</li> <li>• Secure Video Conferencing</li> </ul> <p><del>Remote support</del> <u>Telehealth</u> must:</p> <ul style="list-style-type: none"> <li>• be elected by the <u>individual member</u> receiving services;</li> <li>• not block the member’s access to the community;</li> <li>• not prohibit needed in-person services for the member;</li> <li>• utilize a HIPPA compliant platform; and</li> <li>• prioritize the integration of the member into the community.</li> </ul> <p>For each utilization, providers must document that the <del>remote support</del> <u>telehealth</u> option:</p> <ul style="list-style-type: none"> <li>• was elected by the member receiving services;</li> <li>• did not block the member’s access to the community;</li> <li>• did not prohibit needed in-person services for the member;</li> <li>• utilized a HIPAA-compliant platform; and</li> <li>• prioritized the integration of the <u>individual member</u> into the community.</li> </ul> <p>The keys to providing better member care lies in making services available and ensuring members seek help when necessary. <del>Remote support</del> <u>Telehealth</u> options are for the benefit of the member, rather than the benefit of the provider. The member’s election to utilize <del>remote support</del> <u>telehealth</u> must enhance their integration into the community. Examples of the appropriate use of <del>remote support</del> <u>telehealth</u> include:</p> <ul style="list-style-type: none"> <li>• Members with behavioral health conditions who are feeling stigmatized and, thus, avoiding seeking services <del>in an effort to</del> hide their conditions from others. <del>Remote support</del> <u>Telehealth</u> 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. <del>Remote support</del> <u>Telehealth</u> 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.</li> <li>• Members <del>in the midst of</del> <u>amid a crisis situation</u> 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.</li> </ul> <p>Agencies must have records available for <del>NDDHHS Medical Services Division or contracted</del> <u>MCO</u> review documenting that individual providers have knowledge of and competency in the following:</p> <ul style="list-style-type: none"> <li>○ Person-Centered Plan Implementation</li> </ul>
X	<p>Medically needy (<i>specify limits</i>):</p> <p>Same limits as those for categorically needy.</p>



<b>Provider Qualifications</b> (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  <u>NDDHHS Medical Services Division</u> defines billing group provider as an individual or entity that <del>is able to</del> can enroll to provide 1915(i) services. Depending on their licensure or <del>certification or certification #</del> , certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency, <del>and others are not.</del> Examples of	None	None	A provider of this service must meet <del>all of</del> all the following criteria: <ul style="list-style-type: none"> <li>○ Have a North Dakota Medicaid provider agreement and attest to the following:</li> <li>○ individual practitioners meet the required qualifications</li> <li>○ services will be provided within their scope of practice</li> <li>○ individual practitioners will have the required competencies identified in the service scope</li> <li>○ agency conducts training in accordance with state policies and procedures</li> <li>○ 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 <u>NDDHHS—Medical Services Division</u> review upon request</li> <li>○ agency availability, or the identification of another community resource available 24 hours a day, 7 days a week to clients in need of emergency services</li> <li>○ Member of the North Dakota Continuum of Care (NDCOC)</li> </ul>

<p><del>practitioners that could enroll independently without being affiliated to a clinic, hospital, or other entity: Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Psychologist, Nurse Practitioner and Physician. These practitioners are considered 'other Licensed practitioners'</del><sup>2</sup> (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice.</p>			
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<p>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 <del>agency</del> <del>in</del> <del>agency</del> 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.</p>			
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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 from an 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.
<b>Verification of Provider Qualifications</b> (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.	
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	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. (Select one):**

<input checked="" type="checkbox"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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. <i>(Specify criteria):</i>

**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):**

<input type="checkbox"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="checkbox"/>	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. <i>(Specify the areas of the state affected by this option):</i>

**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
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	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 and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness 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
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8. **Opportunities for Participant-Direction**

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

<input checked="" type="checkbox"/>	The state does not offer opportunity for participant-employer authority.
<input type="checkbox"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> 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.
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> 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 in payment for medical assistance to the individual). *(Select one):*

<input checked="" type="checkbox"/>	The state does not offer opportunity for participants to direct a budget.
	Participants may elect Participant–Budget Authority.
	<b>Participant-Directed Budget.</b> (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.):
	<b>Expenditure Safeguards.</b> (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
<b>Discovery</b>	
<b>Discovery Evidence</b> (Performance Measure)	The number and percent of participant <sup>2</sup> s with POCs that identify and address the participant’s assessed needs. $N = \text{Number of POCs that identify and address the participant’s assessed needs as evidenced by completed assessment indicated on the POC.}$ $D = \text{Total number of participants POCs reviewed with POCs.}$
<b>Activity</b>	<del>Source: The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level) All plans of care are reviewed and approved by program staff on an ongoing basis. with a +/- 5 percent margin of error).</del>

<p><i>(Source of Data &amp; sample size)</i></p>	<p><del>Sample Size: Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the “total population”. Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p> <p><del>The following questions will be included on a checklist developed for use in the review of the representative samples:</del></p> <p><del>Does the POC identify and address assessed needs of the participant?</del></p>
<p><b>Monitoring Responsibilities</b></p> <p><i>(Agency or entity that conducts discovery activities)</i></p>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division and contracted MCO</u></p>
<p><b>Frequency</b></p>	<p><del>Annually</del> <u>Ongoing, continual</u></p>
<p><b>Remediation</b></p>	
<p><b>Remediation Responsibilities</b></p> <p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division and contracted MCO</u></p> <p><u>Ongoing, continual</u> <del>Annually</del></p>
<p><b>Frequency</b></p> <p><i>(of Analysis and Aggregation)</i></p>	<p><del>Annual</del> <u>Ongoing, continual</u></p>



<b>Requirement</b>		<b><i>1b. POCs are updated annually</i></b>
<b>Discovery</b>		
<b>Discovery Evidence</b>  <i>(Performance Measure)</i>	<p>The number and percent of participants with POCs reviewed and revised on or before the required annual review date.</p> <p><i>N= Total number of POCs that were updated annually.</i></p> <p><i>D= Total number of <del>POCs reviewed which were due for annual review</del> members who were eligible for more than 12 consecutive months.-</i></p>	
<i>(Source of Data &amp; sample size)</i>	<p><b>Sample Size:</b> <i>Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size <del>510%</del> of all members who were eligible for more than 12 consecutive months will be determined by the “total population”. Total Population equals the number of completed POCs at the point in time the sample is drawn.</i></p> <p><i>The following question will be included on a checklist developed for use in the review of the representative samples:</i></p> <p><i>Was the POC reviewed and revised on or before the required annual review date?</i></p>	
<b>Monitoring Responsibilities</b>  <i>(Agency or entity that conducts discovery activities)</i>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division and contracted MCO</u></p>	
<b>Frequency</b>	Annual	
<b>Remediation</b>		
<b>Remediation Responsibilities</b>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services and contracted MCO</u></p>	

<p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>Annual</p>
<p><b>Frequency</b>  <i>(of Analysis and Aggregation)</i></p>	<p>Annual</p>

<p><b>Requirement</b></p>	<p><del><i>I.e. POCs are updated/revised when warranted by changes in the participant's needs.</i></del></p>
<p><del><b>Discovery</b></del></p>	
<p><del><b>Discovery Evidence</b></del>  <del><i>(Performance Measure)</i></del></p>	<p><del>The total number and percent of participant's POC revised when warranted by changes in the participant's needs.</del>  <del>N=Number of POCs revised when warranted by changes in the participant's needs.</del>  <del>D=Total number of POCs reviewed which warranted revision due to changes in the participant's needs.</del></p>
<p><del><b>Discovery Activity</b></del>  <del><i>(Source of Data &amp; sample size)</i></del></p>	<p><del>Source: The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del>  <del>Sample Size: Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the "total population". Total Population equals the number of completed POCs at the point in time the sample is drawn.</del>  <del>The following question will be included on a checklist developed for use in the review of the representative samples:</del>  <del><i>Was the POC reviewed and revised when warranted by changes in the participant's needs?</i></del></p>
<p><del><b>Monitoring Responsibilities</b></del></p>	<p><del>NDDHHS Behavioral Health Division</del></p>

<del>(Agency or entity that conducts discovery activities)</del>	
<b>Frequency</b>	<del>Annual</del>
<b>Remediation</b>	
<b>Remediation Responsibilities</b>	<del>NDDHHS Behavioral Health Division</del>
<del>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</del>	<del>Annual</del>
<b>Frequency</b>	<del>Annual</del>
<del>(of Analysis and Aggregation)</del>	

<b>Requirement</b>	<del><b>1d.c. POCs document choice of services and providers.</b></del>
<b>Discovery</b>	
<b>Discovery Evidence</b>	Total number and percent of signed POCs containing a Choice of Service and Provider Statement signed by the participant as proof of choice of eligible services and available providers.
<del>(Performance Measure)</del>	<del><math>N</math>=Total number of POCs containing a Choice of Service and Provider Statement signed by the participant.</del>
	<del><math>D</math>=Total number of participants with POCs. <math>D</math>=Total number of POCs reviewed.</del>
<b>Discovery Activity</b>	<del>All plans of care are reviewed and approved by program staff on an ongoing basis. <b>Source:</b> The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population</del>

<p><i>(Source of Data &amp; sample size)</i></p>	<p><del>(95% confidence level with a +/- 5 percent margin of error).</del></p> <p><del>Sample Size: Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the "total population". Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p> <p><del>The following questions will be included on a checklist developed for use in the review of the representative samples:</del></p> <p><del>Does the POC document the participant had choice of services?</del>  <del>Does the POC document the participant had choice of providers?</del></p>
<p><b>Monitoring Responsibilities</b></p> <p><i>(Agency or entity that conducts discovery activities)</i></p>	<p><del>NDDHHS Behavioral Health Division Medical Services Division and contracted MCO</del></p>
<p><b>Frequency</b></p>	<p><del>Annual Ongoing, continual</del></p>
<p><b>Remediation</b></p>	
<p><b>Remediation Responsibilities</b></p> <p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p><del>NDDHHS Behavioral Health Division Medical Services Division and contracted MCO</del></p> <p><del>Annual Ongoing, continual</del></p>
<p><b>Frequency</b></p> <p><i>(of Analysis and Aggregation)</i></p>	<p><del>Annual Ongoing, continual</del></p>

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.

<b>Requirement</b>	<i>2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all <del>individuals</del> <u>applicants</u> for whom there is a reasonable indication that 1915(i) services may be needed in the future.</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	<p>The number and percent of participants <del>with POC indicating they had an evaluation for 1915(i) eligibility prior to enrollment whose applications were evaluated for eligibility</del></p> <p><i>N=The number of <del>participants with POCs indicating they had an evaluation for 1915(i) eligibility prior to enrollment</del> <u>applicants whose applications were evaluated for eligibility.</u></i></p> <p><i>D=The total number of <del>POCs reviewed</del> <u>applicants.</u></i></p>
<i>(Source of Data &amp; sample size)</i>	<p><b>Sample Size:</b> <del>Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be 100% of all applicants determined by the “total population”. Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p> <p><del>The following question will be included on a checklist developed for use in the review of the representative samples:</del></p> <p><i><del>Does the POC indicate an evaluation for 1915(i) eligibility occurred prior to enrollment?</del></i></p>
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	<del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division</u>
<b>Frequency</b>	Annual

<b>Remediation</b>	
<b>Remediation Responsibilities</b>  <i>(Who corrects, analyzes, and aggregates remediation activities; required)</i>	<a href="#">NDDHHS Behavioral Health Division</a> <a href="#">Medical Services Division</a>  Annual
<i>timeframes for remediation)</i>	
<b>Frequency</b>  <i>(of Analysis and Aggregation)</i>	Annual

<b>Requirement</b>	<b>2b. The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.</b>
<b>Discovery</b>	
<b>Discovery Evidence</b>  <i>(Performance Measure)</i>	<p>The number and percent of participant eligibility reviews completed according to the process and instruments described in the state plan amendment.</p> <p><i>N=The total number of participants' eligibility reviews completed according to the process and instruments described in the state plan amendment.</i></p> <p><i>D=The total number of participant's eligibility reviews.</i></p>
<b>Discovery Activity</b>  <i>(Source of Data &amp; sample size)</i>	<p><del>Record review of 5% of all applicants during the review period. <b>Source:</b> The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del></p> <p><del><b>Sample Size:</b> Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the "total population". Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p>

	<p>The following question will be included on a checklist developed for use in the review of the representative samples:</p> <p><i>Does the POC indicate the process and instruments described in the approved state plan for determining 1915(i) eligibility were applied appropriately?</i></p>
<p><b>Monitoring Responsibilities</b>  (Agency or entity that conducts discovery activities)</p>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division</u></p>
<p><b>Frequency</b></p>	<p>Annual</p>
<p><b>Remediation</b></p>	
<p><b>Remediation Responsibilities</b>  (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</p>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division</u></p> <p>Annual</p>
<p><b>Frequency</b>  (of Analysis and Aggregation)</p>	<p>Annual</p>

<p><b>Requirement</b></p>	<p><i>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.</i></p>
<p><b>Discovery</b></p>	
<p><b>Discovery Evidence</b></p>	<p>The number and percent of participants whose eligibility was reviewed <u>within 365 days of their previous eligibility review at least annually.</u></p>

<p><i>(Performance Measure)</i></p>	<p><i>N=The number of 1915(i) participants whose eligibility was <del>reviewed within 365 days of their previous eligibility review</del>reevaluated at least annually, within the same month or earlier.-</i></p> <p><i>D=The total number of 1915(i) participant <u>eligibility reviews</u> whose annual eligibility review was required.</i></p>
<p><b>Discovery Activity</b></p> <p><i>(Source of Data &amp; sample size)</i></p>	<p><del>Source: The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error). Record review, 5% review of all participants that have participated at any time during the review period.</del></p> <p><del>Sample Size: Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the “total population”. Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p>
	<p><del>The following question will be included on a checklist developed for use in the review of the representative samples:</del></p> <p><del><i>Does the POC indicate the participant’s eligibility was reviewed within 365 days of their previous eligibility review?</i></del></p>
<p><b>Monitoring Responsibilities</b></p> <p><i>(Agency or entity that conducts discovery activities)</i></p>	<p><del>NDDHHS Behavioral Health Division</del><u>Medical Services Division</u></p>
<p><b>Frequency</b></p>	<p>Annual</p>
<p><b>Remediation</b></p>	
<p><b>Remediation Responsibilities</b></p> <p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p><del>NDDHHS Behavioral Health Division</del><u>Medical Services Division</u></p> <p>Annual</p>



<b>Frequency</b>  <i>(of Analysis and Aggregation)</i>	Annual
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**3. Providers meet required qualifications.**

<b>Requirement</b>	<b>3a. Providers meet required qualifications (initially <u>and ongoing</u>).</b>
<b>Discovery</b>	
<b>Discovery Evidence</b>  <i>(Performance Measure)</i>	<p>Number and percent of service providers who <del>initially</del> met required licensure and/or authorization standards prior <u>and ongoing</u> to furnishing 1915(i) services.</p> <p><i>N=The total number of service providers who met required qualifications prior to furnishing 1915(i) Services.</i></p> <p><i>D=The total number of 1915(i) <del>newly authorized service provider applications and revalidations.</del></i></p>
<b>Discovery Activity</b>  <i>(Source of Data &amp; sample size)</i>	<p><u>Review MMIS provider enrollment for all 1915(i) provider applications and revalidations, 100% review.</u></p> <p><del><b>Source:</b> The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del></p> <p><del><b>Sample Size:</b> Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the “total population”. Total Population equals the active providers who initially enrolled during the review period.</del></p>
<b>Monitoring Responsibilities</b>  <i>(Agency or entity that conducts discovery activities)</i>	<del>NDDHHS Medical Services Division <u>Provider Enrollment</u></del>

<b>Frequency</b>	Initially upon enrollment <u>and at scheduled revalidation</u>
<b>Remediation</b>	
<b>Remediation Responsibilities</b>  <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<del>NDDHHS</del> Medical Services Division <del>Provider Enrollment</del>
<b>Frequency</b>  <i>(of Analysis and Aggregation)</i>	Annually <u>and at scheduled revalidation</u>

<b>Requirement</b>	<del>3b. Providers meet required qualifications (ongoing).</del>
<b>Discovery</b>	
<b>Discovery Evidence</b>  <i>(Performance Measure)</i>	<del>The number and percent of reauthorized providers who met required qualifications prior to reauthorization.</del>  <del>N=The number of 1915(i) providers reauthorized who met required qualifications prior to reauthorization.</del>  <del>D=The total number of 1915(i) providers reauthorized.</del>
<i>(Source of Data &amp; sample size)</i>	<del><b>Source:</b> The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del>  <del><b>Sample Size:</b> Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the “total population”. Total Population equals the active providers who re-enrolled during the review period.</del>
<b>Monitoring</b>	<del>NDDHHS</del> Medical Services Division <del>Provider Enrollment</del>

<b>Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	
<b>Frequency</b>	<del>5 years at the time of reenrollment.</del>
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required)</i>	<del>NDDHHS Medical Services Division Provider Enrollment</del>
<i>timeframes for remediation)</i>	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	<del>Annually</del>

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).

<b>Requirement</b>	<i>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).</i>
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	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.

	<p><i>N=Total number of participants whose <del>residential-service settings met the home and/or community-based settings requirement prior to enrollment</del> are in home and community-based settings.</i></p> <p><i>D=Total number of <del>POCs reviewed</del> participants with plans of care.</i></p>
<p><b>Discovery Activity</b></p> <p><i>(Source of Data &amp; sample size)</i></p>	<p><del>Ongoing, continual through plan of care reviews.</del> <b>Source:</b> <del>The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del></p> <p><b>Sample Size:</b> <del>Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the "total population". Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p> <p><del>The following questions will be included on a checklist developed for use in the review of the representative samples:</del></p> <p><i>Does the POC document the participant resides in and 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)?</i></p>
<b>Monitoring</b>	<del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division and contracted MCO</u>
<p><b>Responsibilities</b></p> <p><i>(Agency or entity that conducts discovery activities)</i></p>	
<b>Frequency</b>	<del>Ongoing, continual</del> <u>Annually</u>
<b>Remediation</b>	
<b>Remediation Responsibilities</b>	<del>NDDHHS Behavioral Health Division</del> <u>Medical Services and contracted MCO</u>

<p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	
<p><b>Frequency</b>  <i>(of Analysis and Aggregation)</i></p>	<p><a href="#">Annually</a>Ongoing, continual</p>

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

<p><b>Requirement</b></p>	<p><b>5a. The SMA retains authority and responsibility for program operations and oversight.</b></p>
<p><b>Discovery</b></p>	
<p><b>Discovery Evidence</b>  <i>(Performance Measure)</i></p>	<p><i>N=Number of annual reports submitted to CMS timely</i>  <i>D=Number of annual reports due</i></p>
<p><b>Discovery Activity</b>  <i>(Source of Data &amp; sample size)</i></p>	<p><a href="#">NDDHHS</a> Medical Services  Division 100%</p>
<p><b>Monitoring Responsibilities</b>  <i>(Agency or entity that conducts discovery activities)</i></p>	<p><a href="#">NDDHHS</a> Medical Services Division</p>

<b>Frequency</b>	Annually
<b>Remediation</b>	
<b>Remediation Responsibilities</b>  <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<del>NDDHHS</del> Medical Services Division
<b>Frequency</b>  <i>(of Analysis and Aggregation)</i>	Annually

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

<b>Requirement</b>	<b>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.</b>
<b>Discovery</b>	
<b>Discovery Evidence</b>  <i>(Performance Measure)</i>	Number and percent of claims for provider managed services paid during the review period according to the service rate.  <i>N=Number of claims for provider managed services paid during the review period according to the service rate</i>  <i>D=Number of claims for provider managed services submitted during the review period</i>
<b>Discovery Activity</b>	<del>Financial claims records; minimum 5-10% review of all claims. Source: The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del>

<i>(Source of Data &amp; sample size)</i>	<del>Sample Size: Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the “total population”. Total Population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.</del>
<b>Monitoring Responsibilities</b>  <i>(Agency or entity that conducts discovery activities)</i>	<del>NDDHHS</del> Medical Services Division <u>and contracted MCO</u>
<b>Frequency</b>	Annually
<b>Remediation</b>	
<b>Remediation Responsibilities</b>  <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<del>NDDHHS</del> Medical Services Division <u>and contracted MCO</u>
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

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

<b>Requirement</b>	<b>7a.</b> <i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
<b>Discovery</b>	

<p><b>Discovery Evidence</b></p> <p><i>(Performance Measure)</i></p>	<p>The number and percent of POCs with participant’s signature indicating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints and reporting procedures.</p> <p><del>In case of a state or national emergency where close contact is not allowed, such as with COVID-19, an electronic signature may be accepted.</del></p> <p><i>N=Total number of POCs with participant’s signature indicating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints and reporting procedures.</i></p> <p><i>D=Total number of 1915(i) participant POCs reviewed.</i></p>
<p><b>Discovery Activity</b></p> <p><i>(Source of Data &amp; sample size)</i></p>	<p><del>All plans of care are reviewed and approved by program staff on an ongoing basis to ensure this acknowledgment. Source: The Source database and/or reports used for Data Collection. The state will utilize the information to aggregate and analyze to determine performance. A representative sample of the population (95% confidence level with a +/- 5 percent margin of error).</del></p> <p><del>Sample Size: Sample size is the method used to select a subset or determine the population reviewed to determine quality. The sample size will be determined by the “total population”. Total Population equals the number of completed POCs at the point in time the sample is drawn.</del></p> <p><del>The following question will be included on a checklist developed for use in the review of the representative samples:</del></p> <p><del>Does the POC contain the participant’s signature stating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints and reporting procedures?</del></p>
<p><b>Monitoring Responsibilities</b></p>	<p><del>NDDHHS Behavioral Health Division Medical Services Division and contracted MCO</del></p>
<p><i>(Agency or entity that conducts discovery activities)</i></p>	
<p><b>Frequency</b></p>	<p><del>Annually</del> <del>Ongoing, continual</del></p>
<p><b>Remediation</b></p>	



<p><b>Remediation Responsibilities</b></p> <p><i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p><del>NDDHHS Behavioral Health Division</del> <u>Medical Services Division and contracted MCO</u></p>
<p><b>Frequency</b></p> <p><i>(of Analysis and Aggregation)</i></p>	<p><del>Annually</del> <u>Ongoing, continual</u></p>

## 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

<p><b>Performance Measures:</b></p> <p><del>NDDHHS</del> <u>Medical Services Division</u> has <del>develop</del> <u>developed</u> performance measures for each required sub-assurance. Each performance measure is stated as a metric (number and/or percentage), and specifies a numerator and dominator, ensuring the performance measure:</p> <ul style="list-style-type: none"> <li>• is measurable,</li> <li>• has face validity,</li> <li>• is based on the correct unit of analysis,</li> <li>• is based on <u>a representative sample of the population (95% confidence level with a +/- 5 percent margin of error, the listed sample size,</u></li> <li>• provides data specific to the state plan benefit undergoing evaluation,</li> </ul>
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- 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**

~~NDDHHS Medical Services Division and contracted MCO will review a representative sample of the population (95% confidence level with a +/- 5 percent margin of error), generated by NDDHHS Decision Support Team samples and for measures below compliant levels.~~

Deficiencies discovered ~~by NDDHHS Behavioral Health Division will~~ will be addressed by providing additional training and supports to contracted entities as appropriate, providers and staff to ensure quality requirements are met.

~~**Sample Size:** Sample size is the method used to select a subset or determine the population reviewed to determine quality. i.e. sample of the population (95% confidence level with a +/- 5 percent margin of error).~~

## 2. Roles and Responsibilities

The ~~NDDHHS Behavioral Health Division~~ ~~Medical Services Division~~ and contracted MCO are accountable for addressing individual problems for and relating to Measures 1, ~~3, 4, 6, 2, 4~~ & 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 ~~Behavioral Health Division~~ ~~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 ~~solutions are documented in an excel spreadsheet or a web-based system by the Behavioral Health Division staff.~~

~~The Medical Services Division is accountable for addressing provider related issues relating to Measures 3, 5 & 6 listed above and will correct identified problems. Remediation efforts may include changes in provider education, training, policy, and sanctions as allowed under NDAC Chapter 75-02-05 Provider Integrity; 75-02-05-05 Grounds for sanctioning providers. Issues and solutions are documented by the appropriate Medical Services Division staff. The state maintains documentation that tracks policy changes, recouped funds and terminations.~~

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

- ~~• A checklist will be developed and used for the review of the representative samples.~~
- Findings of the data collection efforts will be analyzed, and the need for system change identified.
- ~~• NDDHHS Medical Services Division and Behavioral Health Division will meet monthly to evaluate the quality, efficiency and effectiveness of the 1915(i) SPA. Program staff will meet regularly to discuss and resolve issues.~~
- Solutions will be implemented, reviewed, and reevaluated on an ongoing basis. ~~The Behavioral Health Division is accountable for addressing compliance issues relating to Measures 1, 2, 4, & 7; and the Medical Services Division is accountable for addressing compliance issues relating to Measures 3, 5, & 6.~~

## 3. Frequency

Annually

## 4. Method for Evaluating Effectiveness of System

For performance measures trending near or below 85%, ~~NDDHHS Behavioral Health and Medical~~ [Medical Services Division and contracted MCOs](#) will discuss and plan quality improvement strategies (QIS). After the QIS has been implemented, performance measure data will be reviewed quarterly to ensure data is trending toward desired outcomes. Participant health, welfare, and safety will be prioritized above all else. When data analysis reveals the need for system change, ~~NDDHHS~~ [Medical Services Division and contracted MCO](#) will reconvene to revise QIS until success is achieved. Effectiveness of the Quality Improvement Process will be measured through progress towards 1915(i) system goals.