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 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):*

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

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

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

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

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

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

● *(By checking this box, the state assures that):* While the Medicaid division does not directly conduct an administrative function, it supervises the performance of the function and establishes

and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid division. When a function is performed by a division/entity other than the Medicaid division, the division/entity performing that function does not substitute its own judgment for that of the Medicaid division with respect to the application of policies, rules and regulations. Furthermore, the Medicaid division assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

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

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

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

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

- #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
-

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, Behavioral Health, 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 situations:

1) such providers are the only willing and qualified providers in certain geographic areas of the state where there is a mental health provider shortage, as determined by the Department; information on provider shortage areas will be available on our website.
2) such providers are the only willing and qualified providers with experience and knowledge to provide services to individuals who share a common language or cultural background.

The baseline for provider shortage areas for these services is the University of North Dakota Center for Rural Health's ND Mental Health Professional Shortage Areas.
Link to Map: https://ruralhealth.und.edu/assets/2783-12672/nd-mental-hpsa.pdf

Ward, Morton, Burleigh, Grand Forks, & Cass are the only counties in North Dakota which are not Mental Health Professional Shortage Areas.

Mental Health Professional Shortage Areas (MHPSA) are counties with too few mental health providers and services. According to the University of North Dakota Center for Rural Health, the following counties would be considered shortage areas: Divide, Williams, McKenzie, Billings, Golden Valley, Slope, Hettinger, Stark, Bowman, Adams, Grant, Oliver, Mercer, Dunn, McLean, Burke, Renville, Bottineau, Rolette, Towner, Cavalier, Ramsey, Walsh, Nelson, Griggs, Pierce, McHenry, Benson Wells, Sheridan, Kidder, Eddy, Foster, Pembina, Steele, Trail, Barnes, Stutsman, Richland, Ransom, Dickey, Sargent, Emmons, Logan, Lamoure, Sioux, McIntosh, and Mountrail.

In order to ensure conflict of interest standards are met, the NDDHS will put these safeguards in place:

A. The Department 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. Agencies and clinics that provide both assessment and plan development, as well as 1915(i) HCBS must document the use of different professionals.
C. Providers must receive prior service authorization from the Department before providing state plan HCBS to recipients whom they have assessed or created a care plan. The care plan must indicate that recipients were notified of the conflicts and the dispute resolution process, and that the client has exercised their right in free choice of provider after notification of the conflict.
D. Recipients 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 are the Human Service Zones. The written agreement between the NDDHS and the Human Service Zones will require 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. NDDHS will require providers to have written conflict of interest standards and written policy to ensure the independence of persons performing evaluations and assessments, and developing the individual'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;
2. financially responsible for the individual; and
3. empowered to make financial or health-related decisions on behalf of the individual.

H. During the Medicaid eligibility process, the Human Service Zones have the participant sign a Medicaid application which verifies the individual has been informed of their rights and responsibilities with opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E. The Human Service Zones will also provide the participant with a list of available Care Coordination providers for the participant to choose from.
I. The individual's Care Coordinator will also 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 Coordinator 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. All POCs must be submitted to the State Medicaid agency.
K. The State 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.

L. The member, and their family or guardian when applicable, develop and lead the POC Team with assistance from the Care Coordinator. The individuals on the team consist of service providers, community supports and natural supports.
M. The NDDHS is responsible for authorizing all services.
N. The NDDHS will require all providers who assert they are the only willing and qualified provider with experience and knowledge to provide services to individuals who share a common language or cultural background, to submit a request to the NDDHS, along with evidence to support the assertion. The NDDHS will review the evidence and either approve or deny the request.

The Department is constantly evaluating gaps in capacity and provider shortages and working to establish steps to address these barriers to access for recipients of these services.

Once a mental health provider shortage no longer exists in a given county, the Department will prohibit agencies from conducting assessments and care plan development from also delivering state plan HCBS other than care coordination.

The Department will post information on its website regarding the conflict of interest standards.

Department's goal is to ensure that the outcomes are in the best interests of recipients of these services.

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

- Individuals, and families when applicable, are given a brochure containing 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 Community Behavioral Health Administrator, the Medical Services Division, or Protection & Advocacy.

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	10/1/2020	9/30/2021	11,150
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 Line (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*):

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

Evaluation/Reevaluation of Eligibility

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

	Directly by the Medicaid agency
X	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Evaluation/reevaluation of Eligibility is delegated by the state Medicaid Agency to the NDDHS Human Service Zones (Zones). The Zones are government agencies. Zone Eligibility Workers 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, on behalf of the State Medicaid Agency, will verify the completed the evaluation/ reevaluation assessment and use this information to determine eligibility. Zone Eligibility Worker qualifications include:

Minimum Qualifications:

Requires one of the following:

(1) Completion of the eligibility worker one-year certificate program.

(2) Completion of 90 semester hours or 135 quarter hours of a bachelor's degree program.

(3) Graduation from high school or GED and three years of work experience involving processing of claims, loans, financial eligibility benefits, credit reviews, abstracts, taxes, or housing assistance, or working in the clerical, accounting, bookkeeping, legal, financial, business, teaching, investments/financial planning, computer/data processing fields.

(4) Three years of any combination of education and experience listed above.

To ensure integrity of the process, Zone Eligibility Workers 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.

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) as the tool for assessment of needs-based eligibility. Agents administering the WHODAS by interview must be independent and meet qualifications determined by the State Medicaid Agency.

In summary, the WHODAS will be utilized because it is:

- a valid assessment tool;
- an instrument to measure health and determine the level of need of an individual;
- currently utilized in other areas throughout NDDHS Behavioral Health system:
- used across all diseases, including mental, neurological and addictive disorders;

- applicable in HCBS settings;
- a tool to identify standardized need levels;
- applicable across cultures, in all populations across the lifespan;
- directly linked to the International Classification of Functioning, Disability and Health (ICF);

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

1. The WHODAS will initially 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 50 or above is required for 1915(i) eligibility.; and,
2. Secondly 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 resulting 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.

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.

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 care 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 NDDHS 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 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.

In addition, 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. NDDHS 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 providing verification of completion of the WHODAS User Agreement and associated training on the administration and scoring of the WHODAS 2.0* located 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 the WHODAS 2.0 assessment and scores. 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 WHODAS 2.0 assessment using a 1915(i) Eligibility Determination Form. The form will be used to document the individual's diagnosis, name and contact information from diagnosing provider, and permission/ release of information for verification. The form will also document the WHODAS 2.0 assessment and scoring information, name and contact information of the WHODAS administrator and permission/ release of information for verification; or
   b. Zone Eligibility Worker may assist the individual with obtaining proof of diagnosis from their diagnosing provider and proof of WHODAS 2.0 assessment scores.
   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 verify the information provided meets the need-based eligibility requirements;
5. Informing the individual (and family/guardian if applicable) of the eligibility results;
6. Informing individual of their right to choose their Care Coordination provider and providing them with a list of Care Coordination providers;

Eligibility Reevaluation Reviews
Zone Eligibility Workers must complete a reevaluation for each participant at least annually.
It is an option for the NDDHS, Care Coordinator or participant to request a reevaluation prior to the annual timeframe if the participant's needs or change in circumstances deem it necessary. The process for the reevaluation reviews is the same as for the initial evaluation as described above.

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:

- *Have 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 50 or higher on the WHODAS 2.0.* A score of 50 does not require 24/7 monitoring and supervision.

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 50 or higher on the WHODAS 2.0.	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 the population defined below. 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 of the following diagnoses:

ICD-10 Diagnosis Code	ICD-10 Diagnosis Description
F41.0	Panic Disorder (episodic paroxysmal anxiety)
F40.01	Agoraphobia with panic disorder
F40.02	Agoraphobia without panic disorder
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.14	Alcohol abuse with alcohol-induced mood disorder

	F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions	
	F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations	
	F10.280	Alcohol dependence with alcohol-induced anxiety disorder	
	F10.24	Alcohol dependence with alcohol-induced mood disorder	
	F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions	
	F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations	
	F10.232	Alcohol dependence with withdrawal with perceptual disturbance	
	F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder	
	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder	
	F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions	
	F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with Hallucinations	
	F50.02	Anorexia nervosa, binge eating/purging type	
	F50.01	Anorexia nervosa, restricting type	
	F06.4	Anxiety disorder due to known physiological condition	
	F84.5	Asperger's syndrome	
	F90.2	Attention-deficit hyperactivity disorder, combined type	
	F90.8	Attention-deficit hyperactivity disorder, other type	
	F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type	
	F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type	
	F84.0	Autistic disorder	
	F31.81	Bipolar II disorder	
	F31.31	Bipolar disorder, current episode depressed, mild	
	F31.32	Bipolar disorder, current episode depressed, moderate	
	F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features	
	F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	
	F31.0	Bipolar disorder, current episode hypomanic	
	F31.2	Bipolar disorder, current episode manic severe with psychotic features	
	F31.11	Bipolar disorder, current episode manic without psychotic features, mild	
	F31.12	Bipolar disorder, current episode manic without psychotic features, moderate	
	F31.13	Bipolar disorder, current episode manic without psychotic features, severe	
	F31.61	Bipolar disorder, current episode mixed, mild	
	F31.62	Bipolar disorder, current episode mixed, moderate	
	F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	
	F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	
	F31.76	Bipolar disorder, in full remission, most recent episode depressed	
	F31.72	Bipolar disorder, in full remission, most recent episode hypomanic	
	F31.74	Bipolar disorder, in full remission, most recent episode manic	

F31.78	Bipolar disorder, in full remission, most recent episode mixed	
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	
F31.73	Bipolar disorder, in partial remission, most recent episode manic	
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	
F60.3	Borderline personality disorder	
F12.180	Cannabis abuse with cannabis-induced anxiety disorder	
F12.122	Cannabis abuse with intoxication with perceptual disturbance	
F12.188	Cannabis abuse with other cannabis-induced disorder	
F12.150	Cannabis abuse with psychotic disorder with delusions	
F12.151	Cannabis abuse with psychotic disorder with hallucinations	
F12.19	Cannabis abuse with unspecified cannabis-induced disorder	
F12.280	Cannabis dependence with cannabis-induced anxiety disorder	
F12.222	Cannabis dependence with intoxication with perceptual disturbance	
F12.288	Cannabis dependence with other cannabis-induced disorder	
F12.250	Cannabis dependence with psychotic disorder with delusions	
F12.251	Cannabis dependence with psychotic disorder with hallucinations	
F06.1	Catatonic disorder due to known physiological condition	
F20.2	Catatonic schizophrenia	
F14.180	Cocaine abuse with cocaine-induced anxiety disorder	
F14.14	Cocaine abuse with cocaine-induced mood disorder	
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions	
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations	
F14.122	Cocaine abuse with intoxication with perceptual disturbance	
F14.188	Cocaine abuse with other cocaine-induced disorder	
F14.19	Cocaine abuse with unspecified cocaine-induced disorder	
F14.280	Cocaine dependence with cocaine-induced anxiety disorder	
F14.24	Cocaine dependence with cocaine-induced mood disorder	
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions	
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	
F14.222	Cocaine dependence with intoxication with perceptual disturbance	
F14.288	Cocaine dependence with other cocaine-induced disorder	
F91.0	Conduct disorder confined to family context	
F91.2	Conduct disorder, adolescent-onset type	
F91.1	Conduct disorder, childhood-onset type	
F44.7	Conversion disorder with mixed symptom presentation	
F44.4	Conversion disorder with motor symptom or deficit	
F44.5	Conversion disorder with seizures or convulsions	
F44.6	Conversion disorder with sensory symptom or deficit	
F34.0	Cyclothymic disorder	

F22	Delusional disorders	
F94.2	Disinhibited attachment disorder of childhood	
F20.1	Disorganized schizophrenia	
F34.81	Disruptive mood dysregulation disorder	
F44.0	Dissociative amnesia	
F44.9	Dissociative and conversion disorder, unspecified	
F44.1	Dissociative fugue	
F44.81	Dissociative identity disorder	
F44.2	Dissociative stupor	
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)	
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder	
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder	
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions	
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with Hallucinations	
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance	
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)	
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder	
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder	
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with Delusions	
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with Hallucinations	
F42.3	Hoarding disorder	
F18.180	Inhalant abuse with inhalant-induced anxiety disorder	
F18.14	Inhalant abuse with inhalant-induced mood disorder	
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions	
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations	
F18.280	Inhalant dependence with inhalant-induced anxiety disorder	
F18.24	Inhalant dependence with inhalant-induced mood disorder	
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions	
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	
F63.81	Intermittent explosive disorder	
F33.2	Major depressive disorder, recurrent severe without psychotic features	
F33.42	Major depressive disorder, recurrent, in full remission	
F33.41	Major depressive disorder, recurrent, in partial remission	
F33.0	Major depressive disorder, recurrent, mild	
F33.1	Major depressive disorder, recurrent, moderate	
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	

F32.4	Major depressive disorder, single episode, in partial remission	
F32.1	Major depressive disorder, single episode, moderate	
F32.3	Major depressive disorder, single episode, severe with psychotic features	
F32.2	Major depressive disorder, single episode, severe without psychotic features	
F02.81	Major Neurocognitive Disorder Due to Traumatic Brain Injury, with behavioral disturbance	
F02.80	Major Neurocognitive Disorder Due to Traumatic Brain Injury, without behavioral disturbance	
G31.84	Mild Neurocognitive Disorder Due to Traumatic Brain Injury	
F30.3	Manic episode in partial remission	
F30.11	Manic episode without psychotic symptoms, mild	
F30.12	Manic episode without psychotic symptoms, moderate	
F30.2	Manic episode, severe with psychotic symptoms	
F30.13	Manic episode, severe, without psychotic symptoms	
F06.31	Mood disorder due to known physiological condition with depressive features	
F06.32	Mood disorder due to known physiological condition with major depressive-like Episode	
F06.33	Mood disorder due to known physiological condition with manic features	
F06.34	Mood disorder due to known physiological condition with mixed features	
F06.30	Mood disorder due to known physiological condition, unspecified	
F42	Obsessive-compulsive disorder	
F11.122	Opioid abuse with intoxication with perceptual disturbance	
F11.14	Opioid abuse with opioid-induced mood disorder	
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions	
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations	
F11.24	Opioid dependence with opioid-induced mood disorder	
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions	
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	
F91.3	Oppositional defiant disorder	
F84.3	Other childhood disintegrative disorder	
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions	
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations	
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions	
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions	
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations	

F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions	
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations	
F45.41	Pain disorder exclusively related to psychological factors	
F45.42	Pain disorder with related psychological factors	
F41.0	Panic disorder [episodic paroxysmal anxiety] without agoraphobia	
F60.0	Paranoid personality disorder	
F20.0	Paranoid schizophrenia	
F84.9	Pervasive developmental disorder, unspecified	
F43.11	Post-traumatic stress disorder, acute	
F43.12	Post-traumatic stress disorder, chronic	
F06.2	Psychotic disorder with delusions due to known physiological condition	
F06.0	Psychotic disorder with hallucinations due to known physiological condition	
F53	Puerperal psychosis	
F20.5	Residual schizophrenia	
F25.0	Schizoaffective disorder, bipolar type	
F25.1	Schizoaffective disorder, depressive type	
F20.81	Schizophreniform disorder	
F21	Schizotypal disorder	
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic- induced disorder	
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder	
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder	
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder	
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder	
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder	
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder	
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic- induced anxiety disorder	
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic- induced mood disorder	
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic- induced persisting	
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or	

	anxiolytic- induced persisting
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic- induced psychotic
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic- induced psychotic
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic- induced psychotic
F93.0	Separation anxiety disorder of childhood
F24	Shared psychotic disorder
F40.11	Social phobia, generalized
F45.0	Somatization disorder

☐ **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:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
		The provision of 1915(i) services at least monthly
	☒	**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

■	If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: Quarterly

Home and Community-Based Settings

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

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.)

NDDHS 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 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)] will not receive HCBS as federal and state regulations do not allow for this as the individual should receive all care determined necessary from the institution under other Medicaid authorities. However, the state will allow for an individual residing in an institution to undergo a "1915(i) pre-eligibility determination" within 90 days of the individual's identified discharge date in the event the institutional case manager provides the Zone Eligibility Worker with a qualifying diagnosis, WHODAS 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 Service authorization 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 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 CFR 441.710(a)(1)-(2).

Following the 1915(i) eligibility determination, the individual's Care Coordinator is responsible for verifying initial and ongoing HCBS Settings compliance for the location(s) the individual will receive services. The state requires the following process for HCBS Settings Verification:

Category #1: The following settings in which an individual will receive 1915(i) services in are presumed compliant:

> **Any community-based private residence that the participant lives in, including private homes and apartments, which are rented or owned by the participant or legal guardian/caretaker, which are located in typical community neighborhoods where people are living who do not receive home and community-based service.**
>
> **Documentation Required:** The individual or legal guardian is responsible for providing the care coordinator with a valid rental lease or a utility bill, i.e. water, sewer, cable, MDU, etc., in the individual's or guardian's name as proof of home ownership to verify compliance. The Care Coordinator verifies HCBS settings compliance and documents compliance in the individual's POC.

Category #2: The following settings type is not assumed compliant and requires verification through the completion of the HCBS Settings Checklist:

> **A setting where the individual is living with an unrelated caregiver in a provider-owned or controlled residential setting.** (Sober Living Homes, Group Homes, Foster Homes, Treatment Foster Homes, Transitional Living Homes)
>
> Verification of compliance can be obtained from the list of pre-approved, compliant HCBS settings (verified within the previous 365 days), or through a site visit and completion of the HCBS Settings Verification Checklist.
>
> All of the following additional conditions must be met for a Category 2 Setting to be verified as compliant:
>
> (A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document

provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

(B) Each individual has privacy in their sleeping or living unit:
(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;
(2) Individuals sharing units have a choice of roommates in that setting; and
(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(B) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

(C) Individuals are able to have visitors of their choosing at any time; and,

(E) The setting is physically accessible to the individual.

Documentation Required:

The care coordinator will check the state's list of pre-approved, compliant HCBS settings. If the setting is on the list, the care coordinator documents HCBS settings compliance verification on the POC.

If the setting is NOT on the list of pre-approved, compliant HCBS settings, the care coordinator will complete a site review and the HCBS Settings Verification Checklist. The focus is on the setting's current physical characteristics and the location contributing to community integration and people's rights.

If the assessment determines the setting is compliant with the settings rule, the care coordinator will enter verification of compliance into the POC.

If the assessment determines area(s) of non-compliance, the care coordinator will inform the provider the setting is not compliant and assist the provider with identifying solutions to make the setting compliant. The care coordinator will document on the HCBS Settings Checklist area(s) of non-compliance, as well as the required solution(s) in order for the setting to be HCBS settings compliant.

In the case of an individual requiring modifications to the required conditions, the care coordinator in collaboration with the individual, provider and Person-Centered Team will complete the following process:

(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

The heightened scrutiny process only applies to those institutions in Category 4, thus is not applicable to Category 2.

Category #3: The following settings are not compliant. CMS has confirmed that individuals cannot live in any of the following institutions while being recipients of 1915(i) services.

(i) A nursing facility.
(ii) An institution for mental diseases.
(iii) An intermediate care facility for individuals with intellectual disabilities.
(iv) A hospital.

Documentation Required: No assessment or documentation required as these are NOT compliant HCBS settings. If a referral is received by the Zones for an individual residing in one of these institutions, the Zone Eligibility Worker will proceed with determining "pre-eligibility" and place an individual in a "pending status" if a qualifying diagnosis, WHODAS score of 50 or above, and a FPL of 150% or below, along with an identified need for 1915(i) HCBS services are provided. Final eligibility would be determined the day following discharge from the institution.

The heightened scrutiny process only applies to those institutions in Category 4, thus is not applicable to Category 3.

Category #4: The following settings will be presumed to be settings having the qualities of an institution unless CMS determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

- A setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. (State has not identified any of these to date, but it is possible there are, or will be, these types of settings in the state so we have prepared for this.)

- A setting that is located in a building on the grounds of, or immediately adjacent to, a public institution. (State has not identified any of these to date, but it is possible there are, or will be, these types of settings in the state so we have prepared for this.)

- Any other setting that has the effect of isolating individuals from the broader community. (State has not identified any of these to date, but it is possible there are, or will be, these types of settings in the state so we have prepared for this.)

Documentation Required:

The Heightened Scrutiny process must be completed for this category.

The Care Coordinator will conduct a site review, inclusive of completion of the HCBS Settings Verification Checklist. The Care Coordinator will search for evidence demonstrating the setting does not have the qualities of an institution and that it does have the qualities of a HCBS setting. The Care Coordinator will compile the evidence into a report and submit the completed HCBS Settings Verification Checklist and report to the NDDHS. The NDDHS will review the evidence and determine if enough evidence exists to submit to CMS to initiate the Heightened Scrutiny Review Process. If there is sufficient evidence, the setting will be sent to CMS. If there isn't sufficient evidence to justify heightened scrutiny, then the setting will not be sent to CMS for heightened scrutiny and will be deemed non-compliant.

Following a CMS determination that the setting is HCBS compliant, the Care Coordinator will document in the individual's POC and 1915(i) services may be provided in the setting. In addition to this initial HCBS Settings Rule verification, written verification of settings must be continually assessed by the care coordinator and ongoing compliance documented in the POC throughout the individual's eligibility.

Following a CMS determination that the setting is not HCBS compliant, the Care Coordinator will document in the POC and ensure no 1915(i) services are provided in the setting.

The second step in compliance with the HCBS Final Rule will be addressed by the Care Coordinator through the person-centered plan of care process.

The person-centered plan of care process is utilized for each person and care coordinator will continuously implement practices and procedures to meet HCBS requirements. The individual's experiences will be monitored by care coordinator through face-to-face visits. Any identified issues will be remediated by using the person-centered plan of care process, and/or contacting an advocacy organization, and or reporting to the NDDHS.

The Care Coordinator will request 1915(i) participants to contact the them prior to a decision to relocate being made, and inform them their continued 1915(i) eligibility is contingent upon them receiving services in a compliant setting.

If, during the course of the 1915(i) eligibility period, the participant is found to be residing in an institutional, institution-like, or otherwise non-compliant setting, the Care Coordinator will notify

all service providers and the Zone of the change as 1915(i) services can't be provided to an individual residing in a non-compliant setting.

Remediation:
Services will not be delivered in settings before compliance with the settings criteria has been determined. If for any reason a 1915(i) eligible individual is discovered to be living in a setting suspected to be out of compliance, the care coordinator will initiate the appropriate settings verification process for that particular setting category.

If remediation of the setting is a possibility, then:

- The care coordinator, individual, and the person-centered plan of care team, and/or the provider (site owner), will develop a remediation plan. The provider is given 21-days to implement remediation efforts.

At the end of the 21-day remediation period, the care coordinator or provider (site owner) will submit the remediation plan and outcome of the remediation efforts to NDDHS for review by the department's HCBS settings committee. The 1915(i) intends to collaborate with the department's C Waiver Authority's HCBS settings committee. The committee will decide if the setting:

- fully complies;
- will fully comply with additional changes; or
- does not, and cannot, meet community settings requirements.

If a decision is made that the setting fully complies, written correspondence is provided to the care coordinator and/or provider (site owner).

If a decision is made that the setting would comply with additional changes, written correspondence of the required changes is provided to the care coordinator and/or provider (site owner). The provider is given an additional 7 days to remedy and the remediation plan and outcome of the remediation efforts are provided to the department's HCBS settings committee. If the setting has not been remedied, a denial will be issued for that setting. The Care Coordinator will issue a 30-day advance written notice to the participant informing them they are living in a non-compliant setting, and must relocate to a compliant setting within 30 days to continue to receive 1915(i) services.

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 participant informing them they are living in a non-compliant setting and must relocate to a compliant setting within 30 days to continue to receive 1915(i) services.

The care coordinator will provide the individual assistance with finding other HCBS options in their community that fully comply with the rule. Participants will be provided choices among alternative settings that meet the participant'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 relocation to a compliant setting hasn't occurred within the 30 days, the client's 1915(i) eligibility will terminate.

Ongoing Compliance and Monitoring of Settings: NDDHS will provide education on the HCBS Settings Final Rule requirements to community stakeholders, including the 1915(i) care coordinators. A description of the setting in which services are delivered and verification of compliance is required in all Person-Centered Plans. All providers are given NDDHS contacts to request technical assistance as needed.

The QI section of this application contains Requirement #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).*" The Community Settings Rule will be verified on each POC reviewed during the quality assurance reviews completed by the state.

The care coordinator will complete the HCBS Settings Rule Site Visit Review Checklist & Settings Compliance Verification Form for settings requiring a site visit. The following Setting Assessment Tools will be used as an overall guide when completing the checklist to ensure compliance for new settings, to assist in maintaining setting compliance, and to understand the expectations within the requirements.

Home and Community Based Settings Requirements

Contents include:

- Quick Reference containing only the HCBS regulations
- Comprehensive version containing the regulations and the corresponding characteristics

Person-Centered Planning & Service Delivery

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

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

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

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

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 Assessment. Agents administering and scoring the WHODAS must be independent and qualified as defined

in #2. **Qualifications of Individuals Performing Evaluation/Reevaluation** under the Evaluation/Reevaluation Section of this application.

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 the following criteria:

- be employed with an enrolled Medicaid provider of the Care Coordination service, and possess NDDHS required competencies as identified within the Care Coordination service part of this application; and one of the following:
  - have a bachelor's degree in social work, psychology, nursing, sociology, counseling, human development, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation; or
  - have 5 years of supervised, clinical experience working with individuals with SMI, SED, SUD, brain injuries, etc.; or,
  - with accompanying transcript, the NDDHS of Human Services may approve other degrees in a closely related field at the NDDHS's discretion;

An agency that meets all of the following criteria is able to 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 24 hours a day, 7 days a week to clients in need of emergency care coordination services; and,
- agency conducts training in accordance with state policies and procedures; and,
- agency adheres to all 1915(i) standards and requirements; and,
- 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 NDDHS review upon request; and,
- ensure supervisors of care coordination staff have a minimum of:
  - a bachelor's degree in social work, psychology, nursing, sociology, counseling, human development, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation; or,
  - have 5 years of supervised, clinical experience working with individuals with SMI, SED, SUD, brain injuries, etc.; or,

- with accompanying transcript, the NDDHS of Human Services may approve other degrees in a closely related field at the NDDHS's discretion.

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 WHODAS scores, 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 brochure that explains each of the services. Also, a Rights and Responsibility brochure that explains what to expect to include how to requires a fair hearing.

The Care Coordinator assists the participant and guardian and team if applicable with developing the Person-Centered POC. Until a case management system is developed, the state will also rely on the POC as documentation to verify 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 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 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.

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 NDDHS-authorized providers of the chosen service.

As a recommended service is identified, the Care Coordinator will provide the participant with a list of providers containing the names and contact information of available providers. Participants may interview potential service providers and select the provider of each service on the POC. The POC signed by the participant (and parent/guardian as applicable) contains a statement assuring they had a choice of provider.

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

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 uploads all Plans of Care containing all services to be authorized into MMIS for authorization by state 1915i administrators. The POC, inclusive of services requested to be authorized, is uploaded into MMIS.

The process for POC submission and prior authorization of services are the same for the initial POC and all revised POCs.

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):*

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Care Coordination**
Service Definition (Scope)*:*	
Services that assist participants in gaining access to needed 1915(i) and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care Coordination is a required component of the 1915(i)-community based behavioral health service system. The care coordinator is responsible for the development of the plan of care and for the ongoing monitoring of the provision of services included in the participant's plan of care. The Care Coordinator ensures that the participant (and parent/guardian as applicable) voice, preferences, and needs are central to the Person-Centered POC development and implementation. A minimum of one face to face contact between the Care Coordinator and participant per quarter is required. 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 WHODAS 2.0 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 participant's, 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.

D. Referral, Collateral Contacts & Related Activities include scheduling appointments for the individual and connecting the eligible individual with obtaining needed services including:

- activities that help link the individual with health, housing, social, educational, employment and other programs and services needed to address needs and achieve outcomes in the POC;
- systematically engaging culturally relevant community services and supports on behalf of the individual; 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 NDDHS review documenting that Care Coordinators have reviewed the competencies or standards of practice in one of 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.

Agencies must also have records available for NDDHS review as verification that Care Coordinators have reviewed NDDHS approved training materials and acknowledge they are competent in the following areas:

- Person-Centered Plan Development and Implementation; and
- Community 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. 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 – Age 0+; Medically Fragile Waiver – Age 3 to 18; Autism Waiver – Age 0 to 14; Children's Hospice Waiver – Age 0 to 22; Aged & Disabled Waiver – Age 18+; Technology Dependent Waiver – Age 18+. 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 may be utilized for up to 25% of all services provided in a calendar month.

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:
- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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 *(specify limits):*
	Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Care Coordination Services NDDHS 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, 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	None	None	A provider of this service must meet all of the following: • Have a North Dakota Medicaid provider agreement and attest to the following: ○ individual practitioners meet the required qualifications ○ services will be provided within their scope of practice ○ individual practitioners will have the required competencies identified in the service scope ○ agency availability 24 hours a day, 7 days a week to clients in need of emergency care coordination services ○ agency conducts training in accordance with state policies and procedures ○ agency adheres to all 1915(i) standards and requirements ○ agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and

licensed practitioners' (OLP) in the ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			available for NDDHS review upon request The individual providing the service must: 1) be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and 2) have a bachelor's degree in social work, psychology, nursing, sociology, counseling, human development, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation; or have 5 years of supervised, clinical experience working with individuals with SMI, SED, SUD, brain injuries, etc.; or, with accompanying transcript, the NDDHS of Human Services may approve other degrees in a closely related field at the NDDHS's discretion; and, • be supervised by an individual containing these qualifications at a minimum.

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

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

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

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

☐	Participant-directed	●	Provider managed

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

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

Service Definition (Scope)*:*

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

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

A participant's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the WHODAS 2.0 functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a participant's identified goals in the Person-Centered POC and document the participant's progress toward their goals.

Covered activities may include the following:

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

8) gaining an understanding of the individual's behavioral health needs, including medications (purpose and side effects), mental illness or substance use disorder symptomology, and implementation of behavior plans;
9) learning communication and crisis de-escalation skills geared for working with the participants behavioral health needs;
10) training or education on a patient suicide safety plan and counseling on lethal means;
11) systems mediation and advocacy; and,
12) assist with accessing services, transportation arrangements, and coordination of services and appointments.

Agencies must have records available for NDDHS 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):*

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):

l	Categorically needy *(specify limits):*

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

The maximum daily limit for the service is eight (8) hours. The maximum annual limit is 208 hours. 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 NDDHS.

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.

The maximum allowable training budget per year is $500.

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 NDDHS
This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of a service which is offered in both, the individual 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. 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 record and kept on file.

	Remote support may be utilized for up to 25% of all services provided in a calendar month. Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include: • Telephone • Secure Video Conferencing Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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.
x	Medically needy *(specify limits):*
	Same limits as those for categorically needy.
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Training and Supports for Unpaid Caregivers. (RATE #1) NDDHS 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, 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 ND Medicaid	None	None	A provider of this service must meet all of the following criteria: Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request

State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individual	None	Have a minimum of two years of experience working with or caring for individuals in the Target Population; or be certified as a Parent Aide, Mental Health Technician, Behavioral Health Technician, Healthy Families Home Visitor, Parents as Teachers Home Visitor,	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 NDDHS approved certification.

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

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

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

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

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

Services are delivered to participants 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 community based (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 need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the WHODAS 2.0 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.

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

- Sharing stories of recovery and/or advocacy involvement for the purpose of assisting recovery and self-advocacy;
- Serving as an advocate, mentor, or facilitator for resolution of issues
- Assisting in navigating the service system including
- Helping develop self-advocacy skills (e.g. assistance with shared decision making, developing mental health advanced directives).
- Assisting the individual with gaining and regaining the ability to make independent choices and assist individuals 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 individual 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 individuals for the specific purpose of achieving increased community inclusion and participation, independence and productivity.
   - Connecting individuals to community resources and services.
   - Accompanying individuals to appointments and meetings for the purpose of mentoring and support.
   - Helping develop a network for information and support, including connecting individuals with cultural/ spiritual activities, locating groups/programs based on an individual's interest including peer-run programs, and support groups.
6) Peer Relief Services are voluntary short-term and offer interventions to support individuals for adverting a psychiatric crisis. The premise behind peer relief is that psychiatric emergency services can be avoided if less intrusive supports are available in the community.

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

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, 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):*

Peer support services are billed in 15-minutes units. Services are limited to eight (8) hours per day (32 units daily) and 260 hours annually. Service authorizations requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the NDDHS.

Service is limited to individuals age 18 and older.

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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. 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 record and kept on file.

State plan 1915(i) 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.

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

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:
- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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 NDDHS review documenting that individual providers have knowledge of and competency in the following:

- Person-Centered Plan Implementation

■ Medically needy *(specify limits):*

Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
North Dakota Medicaid Enrolled Agency Provider of – Peer Support NDDHS defines	None	None	An enrolled billing group of this service must meet all of the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners (Certified Peer Support Specialists I and II) meet the

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, 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 ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a			required qualifications under NDAC 75-03-43 • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request 2, Require individual practitioners (Certified Peer Support Specialists I and II) maintain current certification standards as required by NDAC 75-03-43-06. Recertification and NDAC 75-03-43-07 Continuing Education

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

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

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

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

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

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

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

	Participant-directed	X	Provider managed

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

Service Title:	**Family Peer Support**

Service Definition (Scope)*:*

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

A 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 WHODAS 2.0 functional needs assessment as part of the initial and annual reevaluation and service authorization/reauthorization process. The Care Coordinator must document a need for the service to support a participant's identified goals in the Person-Centered POC and document the participant's progress toward their goals.

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

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

Peer Support Services Include:
Engagement and Bridging,

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

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

Self-Advocacy, Self-Efficacy, and Empowerment

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

Parent Skill Development

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

Community Connections and Natural Supports

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

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

- Person-Centered Plan Implementation

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

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

(Choose each that applies):

- ● Categorically needy *(specify limits):*

Peer support services are billed in 15-minutes units. Services are limited to eight (8) hours per day (32 units daily) and 260 hours annually. 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 NDDHS.

Services is limited to individuals 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 attending school meetings with the parent/caregiver on behalf of the child.
- Child Care 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 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 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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. 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 record and kept on file.

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

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:

- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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 NDDHS review documenting that individual providers have knowledge of and competency in the following: • Person-Centered Plan Implementation
x	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid Enrolled Agency provider of Family Peer Support NDDHS 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, and others are not. Examples	None	None	An enrolled billing group of this service must meet all of the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners (Certified Peer Support Specialists I and II) meet the required qualifications under NDAC 75-03-43 • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request 2, Require individual practitioners (Certified Peer Support Specialists I and II) maintain current certification standards as required by NDAC 75-03-43-06. Recertification and NDAC 75-03-43-07 Continuing Education

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

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

			• Have one of the following combinations:
			  ▪ High school diploma or GED and at least:
			  • Be a North Dakota Certified Peer Support Specialist II
			  • Three years of work experience as a peer specialist or peer recovery coach including at least 2,250 hours of direct client service; or
			  • Two years of work experience as a peer specialist or peer recovery coach including at least 1500 hours of direct client service, and at least one year of full-time work experience supervising others; or
			  • Associate degree from an accredited college or university and at least two years of work experience as a peer specialist or peer recovery coach including at least 1500 hours of direct client service; or
			  • Bachelor's degree from an accredited college or university and at least two years of full-time work experience supervising others; or
			  • Be the director of an organization providing peer support services; and
			• Have completed a state approved peer support specialist supervision training

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

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

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

Respite Care is a service provided to a participant unable to care for himself/herself. The service is furnished on a short-term basis to provide needed relief to, or because of the absence of, the caregiver, including but not limited to the biological, kin, pre-adoptive, adoptive, and foster parent; and legal guardian.

Respite services are available to participants receiving the HCBS benefit who are residing in his or her family home (biological or kin), legal guardian's home, pre-adoptive/adoptive, or foster home.
Routine respite care may include hourly, daily and overnight support.

A 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 WHODAS 2.0 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.

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

- Person-Centered Plan Implementation

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

- NDDHS-authorized Respite Care provider meeting standards and qualifications for a service provider.
- Any DHS-approved respite program setting licensed by NDDHS.
- A licensed child-care setting.

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

Respite Care may be provided in the participant'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 NDDHS. A facility-based respite care program does not meet the HCBS 1915(c) Community Based Settings Rule.

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 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 unit rate. Maximum number of hours a 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 NDDHS.

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, 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 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 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 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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 21, within the 1915(i) is duplicative of the Respite/In-Home Supports services within the following HCBS 1915(c) Waivers: ID/DD Waiver – Age 0+; Medically Fragile Waiver – Age 3 to 18; Autism Waiver – Age 0 to 14; Children's Hospice Waiver – Age 0 to 22; HCBS Age/Disable Waiver – Ages 18+.

- 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 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.

This service is available to individuals age 0 to age 21 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.

	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 NDDHS of Public Instruction. Payments will not be made for the routine care and supervision which would be expected to be provided by a caregiver for activities or supervision for which payment is made by a source other than Medicaid.
☒	Medically needy *(specify limits):* Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Respite NDDHS 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, and others are not. Examples of practitioners that could enroll independently without being	Family Foster Homes licensed under NDAC 75-03-14; Therapeutic Foster Homes licensed by Licensed Child Placing Agencies under NDAC 75-03-36; Foster Homes for Adults licensed under 75-03-21; Supervised Independent Living Programs licensed under NDAC 75-03-41;	None	A provider of this service must meet all of the following criteria: Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request 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

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 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	Family Child Care Homes licensed under NDAC -75-03-08; Group Child Care licensed under NDAC 75-03-09; Child Care Centers licensed under NDAC 75-03-10; Providers licensed by the NDDHS, Division of Developmental Disabilities under 75-04-01; Qualified Residential Treatment Program Providers licensed by the NDDHS, Children and Family Services Division,		

provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.	under 75-03-40 and enrolled as a Medicaid Provider of Community Based Services; Psychiatric Residential Treatment Facility Providers licensed by the NDDHS, Behavioral Health Division, under NDAC 75-03-17 and enrolled as Medicaid Provider of Community Based Services; Providers licensed by the NDDHS under 75-05-00.1 Human Service Center Licensure Enrolled Qualified Service Provider 75-03-23-07		

	Substance Abuse Treatment Program licensed under NDAC 75-09.1		

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

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

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

	Participant-directed	X	Provider managed

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

Service Definition (Scope):

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

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

A 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 WHODAS 2.0 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.

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

N/A

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

(Choose each that applies):

- ● Categorically needy *(specify limits):*

	NMT will only be available for non-routine, time-limited services, not for ongoing treatment or services or for routine transportation to and from a job or school. All other options for transportation, such as informal supports, community services, and public transportation must be explored and utilized prior to requesting waiver transportation. This service is not intended to replace other transportation services but compliment them. A NMT provider must be enrolled in the ND Medicaid program and meet all applicable motor vehicle and licensing requirements. NMT is solely for transporting the client to and from his/her 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 client's home. Individuals receiving Non-Medical Transportation Services through the ND HCBS 1915(c) authorities including the Medically Fragile Waiver, HCBS Aged/Disabled, and Technology Dependent Waivers are not eligible to receive Non-Medical Transportation through the 1915(i). This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual is required to access the service through the 1915(c) rather than the 1915(i). The state has identified the Non-Medical Transportation service, age 0+, within the 1915(i) is duplicative of the following services within the HCBS 1915(c) Waivers: Medically Fragile Waiver – Age 3 to 18; HCBS Aged/Disable Waiver – Age 18+; and Technology Dependent Waiver – Age 18+. • 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 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.
x	Medically needy *(specify limits):*

Same limits as those for categorically needy.			
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Medicaid Enrolled agency provider of Non-Medical Transportation Provider NDDHS 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, and others are not. Examples of	NDCC Title 39-06 Motor Vehicles and Operating License	None	A provider of this service must meet all of the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request • Agency adheres to ND State Laws regarding motor vehicles, operating licenses and insurance, and uses licensed public transportation carriers The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service. 2) Be at least 18 years of age 3) Have a valid driver's license issued by the State of ND.

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 ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice. These practitioners			

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Enrolled Medicaid agency provider of Non-Medical	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.

Transportation		

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

	Participant-directed	●	Provider managed

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

Service Title:	**Community Transition Services (CTS)**

Service Definition (Scope):

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a NF, ICF, IID, or PRTF to a living arrangement in a private residence where the person is directly responsible for his or her 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;
- ☐ Individual has resided in the ND Medicaid Institution for a minimum of 30 consecutive days, and is transferring from a NF/IID/ICF/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 directly responsible for his or her own living expenses;
- ☐ Individual will be receiving Medicaid or Medicaid Expansion upon discharge form 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 50 or higher; 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. 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 determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Community Transition Services are furnished, as follows:

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

- When 1915(i) Community Transition Services are furnished to individuals returning to the community from a 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):*

Limitations applicable to service delivery: $3,000 to occur within the 180 consecutive days window per participant lifetime.

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual is required to access the service through the 1915(c) rather than the 1915(i).

The state has identified the Community Transition service within the 1915(i) is duplicative of the following services within the HCBS 1915(c) Waivers: ID/DD Waiver – Age 0+; HCBS Aged/Disabled Waiver – Age 18+. Individuals currently or previously receiving Community Transition Services through the HCBS Aging/Disabled or DD Waivers are not eligible to receive Community Transition Services through the 1915(i).

The state will implement the following approach to ensure that 1915(i) services are not duplicative with other Medicaid-funded services: The case manager requesting the Community Transition funding will 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 State Medicaid Office will determine if the member has accessed Community Transition Services in the past, and will not approve the request if prior access is confirmed.

Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services 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.

○

X Medically needy *(specify limits):*

Same limits as those for categorically needy.

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

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

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

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

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

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

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

☐	Participant-directed	●	Provider managed

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

Service Title:	**Benefits Planning Services**

Service Definition (Scope)*:*

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

Benefits Planning services include:

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

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

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 WHODAS 2.0 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.

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) 20 hours per participant per fiscal year. 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 NDDHS.

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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. 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 record and kept on file.

Remote support may be utilized for up to 25% of all services provided in a calendar month.

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:

- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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. Limitations applicable to remote support service delivery of services: o Remote support cannot be used for more than 25% of all benefits planning services in a calendar month.
X	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Benefits Planning Services NDDHS 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 independent			A provider of this service must meet all of the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request.

ly without being affiliated to a clinic, hospital or other agency, 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 ND Medicaid State Plan			

and are allowed to provide any state plan service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individual		Certified Work Incentives	The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service.

		Counselor (CWIC) and Community Partner Work Incentives Counselor (CPWIC).	

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):*
NDDHS enrolled agency provider of Benefits Planning Services	North Dakota Provider of Benefits Planning Services	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

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

	Participant-directed	X	Provider managed

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

Service Title:	**Prevocational Training**

Service Definition (Scope)*:*

Pre-vocational services are time-limited community-based services that prepare an individual for employment or volunteer work. This service specifically provides learning and work experiences where the individual can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings.

Prevocational services are authorized by the Care Coordinator as a support for achieving soft skills needed to attain future employment or volunteer work opportunities. Services are designed to be delivered in and outside of a classroom setting. Services must honor the individual's preferences (scheduling, choice of service provider, direction of work, etc.) and provide consideration for common courtesies such as timeliness and reliability. Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Public Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the

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.
Service components include:

- Teach concepts such as: work compliance, attendance, task completion, problem solving, and safety, and, if applicable, teach individuals 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 individual'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 individuals 6 months before their 18th 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 combined hours (for prevocational services) are limited to no more than eight (8) hours per day (32 units daily) and a total of 156 hours per year. This service is a 15-minute unit rate.

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

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

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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 – Age 18+.

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 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.

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 an individual's supported employment program

Remote support may be utilized for up to 25% of all services provided in a calendar month.

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:

- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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 *(specify limits):*

Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Prevocational Training NDDHS defines billing group provider as an individual or entity that is			A provider of this service must meet all of the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect,

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, 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			exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request Accreditation requirements do not apply to North Dakota Schools enrolled as Medicaid Enrolled Prevocational Providers, however; schools must ensure that paraeducator/ education specialist, and supervisors meet individual requirements. Must meet NDAC 75-04-01 or have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA) or The Council on Quality Leadership (CQL) Accreditation.

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 in order to enroll. Each billing group provider must meet the qualifications specified			

in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individuals		Mental Health First Aid Training for Youth and/or Mental Health First Aid Training for Adults depending on scope of services/ targeted population. Must have one of the following certifications: - Employment Specialists (IPS or CESP) - Certified Brain Injury Specialist; - Qualified Service Provider (QSP); - Direct Service Provider (DSP) - Career	The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service. 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, as a paraeducator/ education specialist and be trained in Mental Health First Aid Training for Youth and/ or Adults depending on the scope of services/ targeted population.

		Development Facilitation	

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

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

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

	Participant-directed	X	Provider managed

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

Service Title:	**Supported Education**

Service Definition (Scope)*:*

Supported Education Services (SEd) are individualized and promote engagement, sustain participation and restore an individual's ability to function in the learning environment. Services must be specified in the person-centered plan of care to enable the individual to integrate more fully into the community and/or educational setting and must ensure the health, welfare and safety of the individual. The goals of SEd are for individuals 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, time management); (4) promote self-advocacy, self-efficacy and empowerment (e.g. disclosure, reasonable accommodations, advancing educational opportunities); and (5) build community connections and natural supports.

A 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 WHODAS 2.0 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.

Supported Education Services (SEd) 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 individual's preferences (scheduling, choice of service provider, direction of work, etc.) and provide consideration for common courtesies such as timeliness and reliability. Services furnished through Medicaid 1915(i) must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur Providers must coordinate efforts with the Department of Public Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the 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.

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

Engage, bridge and transition

- Act as a liaison/support in the educational learning environment.
- Facilitate outreach and coordination.
- Familiarize individual and caregiver (if applicable) to school settings, to help navigate the school system and student services.
- Assist with admission applications and registration.
- Assist with transitions and/or withdrawals from programs such as those resulting from behavioral health challenges, medical conditions and other co-occurring disorders.
- Improve access by effectively linking consumers 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 individuals' 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 individuals 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 American's 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.
- Identify financial aid resources and assist with applications for Financial Aid.
- Assist in applying for student loan forgiveness on previous loans because of disability status.

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

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

None.

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

(Choose each that applies):

X Categorically needy *(specify limits):*

This service is available to individuals age 5 and above.

Services are limited to 8 hours per day (32 units daily) and a maximum of 156 hours annually. 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.

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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. 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 record and kept on file.

Remote support may be utilized for up to 25% of all services provided in a calendar month.

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:

- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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.

X Medically needy *(specify limits):*

Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Prevocational Training NDDHS defines billing group provider as an individual or entity that is able to enroll to provide 1915(i) services. Depending on their licensure	None	None	A provider of this service must meet all the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use

or certification, certain practitioners are allowed to enroll independently without being affiliated to a clinic, hospital or other agency, 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 ND Medicaid State Plan and are allowed to provide any state plan service that is			of restraints and reporting procedures are written and available for NDDHS review upon request Must meet requirements of 75-04-01 or have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA). Accreditation requirements do not apply to North Dakota Schools enrolled as Medicaid Enrolled Supported Education Providers, however; schools must ensure that paraeducator/ education specialist supervisors, and supervisors meet individual requirements.

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.			
Individuals		Mental Health First Aid Training for Youth and/or Mental Health First Aid Training for Adults depending on scope of services/ targeted population; and May have <u>one</u> of the following: - Employment Specialists (IPS or CESP) - Certified Brain Injury Specialist	The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service. 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 Supported Education, as a paraeducator/ education specialist and be trained in Mental Health First Aid Training for Youth and/ or Adults depending on the scope of services/ targeted population. Supervisors of staff providing Supported Education (SEd) services must have a degree in one of the following: bachelors' degree or

		- Direct Support Professional (DSP) - Certified Career Development Facilitator	higher in, disabilities services, business, personnel management, mental health or social services, social work, psychology, nursing, sociology, counseling, human development, education, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation.

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

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

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

Participant-directed		X	Provider managed

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

Service Title:	**Supported Employment**

Service Definition (Scope)*:*

Supported Employment (SEP) services assist individuals 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 individual to maintain their paid competitive employment position. SEP services are individualized, person-centered services providing supports to individuals who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.

SEP services can be provided through many different service models. Some of these models can include evidence-based supported employment, or customized employment for individuals with significant disabilities. SE 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.

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 WHODAS 2.0 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.

Supported Employment services may be furnished to any individual that elects to receive support, and demonstrates a need for the service. Services are authorized during the person-centered planning process by the Care Coordinator to assist the individual with achieving goals identified in the person-centered plan of care. Services must be provided in a manner which honors the individual's preferences (scheduling, choice of provider, direction of work), and consideration for common courtesies such as timeliness and reliability. Services furnished through Medicaid 1915(i) must not duplicate services funded under section 110 of the Rehabilitation Act of 1973. To ensure duplication does not occur, providers must coordinate efforts with the local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the individual through the Vocational Rehabilitation Agency must be identified and documented in the individual'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,
- 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's first day of employment, the provider will work with the individual and members of the individual's team to create a plan for job stabilization. The provider will continue to coordinate team meetings when necessary, follow-up with the participant once they are employed, and provide monthly progress reports to the entire team.

Ongoing Follow-Along Support services are available to an individual 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 individuals 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) and a maximum of 156 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 North Dakota Department of Human Services.

Once an individual has maintained employment for 6 months the individual 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 per week.

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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 – Age 18+; and HCBS Aged/Disabled Waiver – Age 18+.

- 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 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 may be utilized for up to 25% of all services provided in a calendar month.

Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include:

- Telephone
- Secure Video Conferencing

Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the DEA (20 U.S.C. 1400 et seq.). Federal

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

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

■ Medically needy *(specify limits):*

Same limits as those for categorically needy.

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Prevocational Training NDDHS 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,			A provider of this service must meet all of the following criteria: 1. Have a North Dakota Medicaid provider agreement and attest to the following: • individual practitioners meet the required qualifications • services will be provided within their scope of practice • individual practitioners will have the required competencies identified in the service scope • agency conducts training in accordance with state policies and procedures • agency adheres to all 1915(i) standards and requirements • agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request Must meet NDAC 75-04-01 or have accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA) or The Council of Quality Leadership (CQL).

hospital or other agency, 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 ND Medicaid State Plan and are allowed to provide any state plan			

service that is within their scope of practice. These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individuals		Mental Health First Aid Training for Youth and/or Mental Health First Aid Training for Adults	The individual providing the service must: 1) Be employed by an enrolled ND Medicaid enrolled billing group of this service. In lieu of the approved certifications a staff providing services may be uncertified and instead possess education equivalent to a bachelor's degree or higher in vocational services counselor, disabilities services, business,

		depending on scope of services/ targeted population. Must have <u>One</u> of the following certifications: ○ Employment Specialists (IPS or CESP) ○ Certified Brain Injury Specialist; ○ Direct Support Professional (DSP) ○ Qualified Service Provider (QSP) ○ Certified Career Development Facilitator	personnel management, mental health or social services, social work, psychology, nursing, sociology, counseling, human development, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation. The NDDHS of Human Services may approve other degrees in a closely related field at the NDDHS's discretion. Supervisors of staff providing Supported Employment (SEP) services must meet the requirements of a staff providing Supported Employment Services and have two or more years of experience in SEP services.

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

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

North Dakota Medicaid enrolled agency provider of Supported Employment	North Dakota Medicaid Provider Enrollment	Provider will complete an attestation as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.
Service Delivery Method. *(Check each that applies)*:		
Participant-directed	X	Provider managed

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

Housing Supports help individuals' 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 individuals 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 an individual with stabilizing and accessing to the greater community.

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 WHODAS 2.0 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.

Pre-Tenancy services provide individuals the support that is needed to secure housing. Pre-tenancy services are available only to the individual living in the community and may not be billed when an individual is concurrently receiving Tenancy Support services.

Pre-tenancy services include:

- Supporting with applying for benefits to afford housing (e.g., housing assistance, SSI, SSDI, TANF, SNAP, LIHEAP, etc.).
- Assisting with the housing search process and identifying and securing housing of 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 negotiate a lease.
- Helping identify 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 individuals with sustaining tenancy in an integrated setting that supports access to the full and greater community. Tenancy Supports may not be billed when an individual 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 role, 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's home.
- Coordinating and linking individuals to services and service providers in the community that would assist an individual 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 individuals receiving services and supports.

Services are available to individuals six months prior to the 18th birthday.

Individuals eligible to receive 1915(i) state plan amendment services may elect to receive housing support services if the individual:
- 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's rights or privacy, dignity and respect, and freedom from coercion and restraint; optimize individual initiative, autonomy and independence to make life choices; and facilitate individual choice about services and supports and who provides them. Provider-controlled settings must meet additional requirements.

Prior to billing, services must be authorized 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.

Pre-tenancy supports are limited to 78 hours per 3-month authorization period for a maximum of 156 hours per year.

Requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the NDDHS.

Tenancy supports are limited to 78 hours per 6-month authorization period for a maximum of 156 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 NDDHS.

Services may not be duplicated by any other services provided through the Home & Community Based Services 1915(c) waiver.

This service cannot 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. Individuals 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 is enrolled in both the 1915(i) and a 1915(c) waiver and is in need of this service which is offered in both, the individual 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. 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 record and kept on file.

Remote support may be utilized for up to 25% of all services provided in a calendar month.

	Remote support includes real-time, two-way communication between the service provider and the participant. Remote support 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 options include: • Telephone • Secure Video Conferencing Remote support 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 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 options are for the benefit of the member, rather than the benefit of the provider. The member's election to utilize remote support must enhance their integration into the community. Examples of the appropriate use of remote support 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 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 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 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.
X	Medically needy *(specify limits):*
	Same limits as those for categorically needy.
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
North Dakota Medicaid enrolled agency provider of Housing Supports NDDHS 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, and others are not. Examples of	None	None	A provider of this service must meet all of the following criteria: o Have a North Dakota Medicaid provider agreement and attest to the following: o individual practitioners meet the required qualifications o services will be provided within their scope of practice o individual practitioners will have the required competencies identified in the service scope o agency conducts training in accordance with state policies and procedures o agency adheres to all 1915(i) standards and requirements o 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 NDDHS review upon request o agency availability 24 hours a day, 7 days a week to clients in need of emergency services o Member of the North Dakota Continuum of Care (NDCOC)

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 ND Medicaid State Plan and are allowed to provide any state plan service that is within their scope of practice.			

These practitioners are allowed to enroll as their own billing group provider if they choose. If a provider is not an OLP, they must be affiliated to a clinic, hospital or other agency in order to enroll. Each billing group provider must meet the qualifications specified in the 1915(i) state plan pages. The minimum qualifications for the provider are listed under each service.			
Individuals		Mental Health First Aid Training for Youth	Be employed by an enrolled billing group provider; 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

		and/or Mental Health First Aid Training for Adults depending on scope of services/ targeted population .	b. Associate degree in the human service field 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.

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

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

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

☐	Participant-directed	●	Provider managed

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

N/A

Participant-Direction of Services

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

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

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

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

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐

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

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

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

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers 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

8. Opportunities for Participant-Direction

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

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

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

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

Quality Improvement Strategy

Quality Measures

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

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

Requirement	***1a. POCs address assessed needs of the 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participant's with POCs that identify and address the participant's assessed needs. *N=Number of POCs that identify and address the participant's assessed needs.* *D=Total number of participant POCs reviewed.*
Discovery Activity	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error).

	(Source of Data & sample size)	**Sample Size:** 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. The following questions will be included on a checklist developed for use in the review of the representative samples: *1. Does the POC identify and address assessed needs of the participant?*
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annually
	Frequency *(of Analysis and Aggregation)*	Annual

Requirement	***1b. POCs are updated annually***
Discovery	

	Discovery Evidence *(Performance Measure)*	The number and percent of participants with POCs reviewed and revised on or before the required annual review date. *N= Total number of POCs that were updated annually.* *D= Total number of POCs reviewed which were due for annual review.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following question will be included on a checklist developed for use in the review of the representative samples: *Was the POC reviewed and revised on or before the required annual review date?*
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
	Frequency	Annual
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annual

Frequency *(of Analysis and Aggregation)*	Annual

Requirement	***1c. POCs are updated/revised when warranted by changes in the participant's needs.***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number and percent of participant's POC revised when warranted by changes in the participant's needs. N=Number of POCs revised when warranted by changes in the participant's needs. D=Total number of POCs reviewed which warranted revision due to changes in the participant's needs.
Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following question will be included on a checklist developed for use in the review of the representative samples: *Was the POC reviewed and revised when warranted by changes in the participant's needs?*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
Frequency	Annual
Remediation	
Remediation Responsibilities	NDDHS Behavioral Health Division

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

Requirement	***1d. POCs document choice of services and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of signed POCs containing a Choice of Service and Provider Statement signed by the participant as proof of choice of eligible services and available providers. *N=Total number of POCs containing a Choice of Service and Provider Statement signed by the participant.* *D=Total number of POCs reviewed.*
Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following questions will be included on a checklist developed for use in the review of the representative samples: *Does the POC document the participant had choice of services?* *Does the POC document the participant had choice of providers?*
Monitoring Responsibilities	NDDHS Behavioral Health Division

	(Agency or entity that conducts discovery activities)	
	Frequency	Annual
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annual
	Frequency *(of Analysis and Aggregation)*	Annual

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

Requirement		***2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all individuals for whom there is a reasonable indication that 1915(i) services may be needed in the future.***
Discovery		
	Discovery Evidence	The number and percent of participants enrolled within the current month under review, with POC indicating they had an evaluation for 1915(i) eligibility prior to enrollment.

	(Performance Measure)	*N=The number of participants enrolled within the current month, with POCs indicating they had an evaluation for 1915(i) eligibility prior to enrollment* *D=The total number of POCs of new enrollees reviewed*
	Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following question will be included on a checklist developed for use in the review of the representative samples: *Does the POC indicate an evaluation for 1915(i) eligibility occurred prior to enrollment?*
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
	Frequency	Annual
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annual
	Frequency	Annual

	(of Analysis and Aggregation)	

Requirement		***2b. The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participant eligibility reviews completed according to the process and instruments described in the state plan amendment. *N=The total number of participants' eligibility reviews completed according to the process and instruments described in the state plan amendment.* *D=The total number of participant's eligibility reviews*
	Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following question will be included on a checklist developed for use in the review of the representative samples: *Does the POC indicate the process and instruments described in the approved state plan for determining 1915(i) eligibility were applied appropriately?*
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
	Frequency	Annual

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annual
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	***2c. The 1915(i) benefit eligibility of enrolled participants is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants whose eligibility was reviewed within 365 days of their previous eligibility review. *N=The number of 1915(i) participants whose eligibility was reviewed within 365 days of their previous eligibility review.* *D=The total number of 1915(i) participants whose annual eligibility review was required.*
Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following question will be included on a checklist developed for use in the review of the representative samples: *Does the POC indicate the participant's eligibility was reviewed within 365 days of their previous eligibility review?*

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
Frequency	Annual
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annual
Frequency *(of Analysis and Aggregation)*	Annual

3. Providers meet required qualifications.

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

		D=The total number of 1915(i) authorized service providers.
	Discovery Activity *(Source of Data & sample size)*	NDDHS Medical Services Division at time of Provider Enrollment 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Medical Services Division Provider Enrollment Process
	Frequency	Initially upon enrollment
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Medical Services Division Provider Enrollment Process Annually
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***3b. Providers meet required qualifications (ongoing).***
Discovery	

	Discovery Evidence *(Performance Measure)*	The number and percent of reauthorized providers who met required qualifications prior to reauthorization. *N=The number of 1915(i) providers reauthorized who met required qualifications prior to reauthorization* *D=The total number of 1915(i) providers reauthorized*
	Discovery Activity *(Source of Data & sample size)*	NDDHS Medical Services Division Provider Enrollment Process 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Medical Services Division Provider Enrollment Process
	Frequency	5 years at the time of reenrollment.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Medical Services Division Provider Enrollment Process Annually
	Frequency *(of Analysis and Aggregation)*	Annually

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

Requirement	***4a. Settings meet the home and community-based setting requirements as specified in the SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of participants whose POC indicate a setting for service delivery that meets the home and community-based settings requirements as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2) prior to enrollment. *N=Total number of participants whose residential settings met the home and community-based settings requirement prior to enrollment.* *D=Total number of POCs reviewed.*
Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following questions will be included on a checklist developed for use in the review of the representative samples: *1. 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)?*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division

	Frequency	Annual
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Behavioral Health Division Annual
	Frequency *(of Analysis and Aggregation)*	Annual

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

Requirement		***5a. The SMA retains authority and responsibility for program operations and oversight.***
Discovery		
	Discovery Evidence *(Performance Measure)*	*N=Number of annual reports submitted to CMS timely* *D=Number of annual reports due*
	Discovery Activity *(Source of Data & sample size)*	NDDHS Medical Services Division 100%
	Monitoring Responsibilities	NDDHS Medical Services Division

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

Requirement		***6a. The SMA maintains financial accountability through payment of claims for provider managed services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims for provider managed services paid during the review period according to the service rate. *N=Number of claims for provider managed services paid during the review period according to the service rate* *D=Number of claims for provider managed services submitted during the review period*

	Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Medical Services Division
	Frequency	Annual
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	NDDHS Medical Services Division Annual
	Frequency *(of Analysis and Aggregation)*	Annual

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

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

Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of POCs with participant's signature indicating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints and reporting procedures. 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. *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.* *D=Total number of 1915(i) participant POCs reviewed.*
	Discovery Activity *(Source of Data & sample size)*	**Source:** A representative sample of the population (95% confidence level with a +/-5 percent margin of error). **Sample Size:** 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. The following question will be included on a checklist developed for use in the review of the representative samples: *Does the POC contain the participant's signature stating they were informed of their rights surrounding abuse, neglect, exploitation, use of restrains and reporting procedures?*
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	NDDHS Behavioral Health Division
	Frequency	Annual
Remediation		
	Remediation Responsibilities	NDDHS Behavioral Health Division

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

System Improvement

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

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

Performance Measures:
NDDHS has develop 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:

- is measurable,
- has face validity,
- is based on the correct unit of analysis,
- is based on a representative sample of the population (95% confidence level with a +/-5 percent margin of error,
- provides data specific to the state plan benefit undergoing evaluation,
- demonstrates the degree of compliance for each period of data collection, and
- measures the health of the system, as opposed to measuring a beginning step in the process.

Discovery and Remediation
NDDHS will review a representative sample of the population (95% confidence level with a +/-5 percent margin of error), generated by NDDHS Decision Support Team.
Sample Size: 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.

In addition, NDDHS will create a checklist containing the Performance Measures 1a, b, c, d; 2a, b, c; 4a; 7a; contained in this section and will require the Care Coordination providers to use this checklist to self-monitor their work by completing reviews of their POCs and files. The NDDHS will also develop a Reporting Template for the Care Coordination provider to report their findings following their reviews. This "self-monitoring" component completed by the provider

will be in addition to the reviews completed by the NDDHS. This self-monitoring will complement the NDDHS monitoring process, rather than replace it.

2. Roles and Responsibilities

The NDDHS Behavioral Health Division is accountable for addressing individual problems for and relating to Measures 1, 2, 4 & 7 listed above. and will correct identified problems by providing training, clarify policy or other system improvement methods. Upon discovery of an issue, the Behavioral Health Division will contact the care coordinator or Zone to resolve the issue through training, policy clarification or other improvement measures. Issues and 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 86% 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.
- NDDHS Medical Services Division and Behavioral Health Division will meet monthly to evaluate the quality, efficiency and effectiveness of the 1915(i) SPA.
- 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 Changes

For performance measures trending near or below 85%, NDDHS Behavioral Health and Medical Services Divisions 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, NDDHS 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.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

The agency's fee schedule rates for all of the following services will be set as of October 1, 2020 and will be effective for services provided on or after that date. The rates will be published at the State's website, http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html

●	HCBS 1915(c) Case Management
	Care Coordination is a 15-minute unit rate. The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
	HCBS Habilitation
●	HCBS Respite Care
	The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data

	submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Other Services (specify below)
	Peer Support - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Housing Supports - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Supported Employment - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Training and Supports for Unpaid Caregivers - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. There are two parts to this service and a separate rate for each. Provision of this service is available as:

	1) Rate #1: A service based on a unit rate for one-on-one or group training and support by an approved service provider, i.e. parent aide, mental health technician, etc., as identified in the Provider Qualifications below, and; and 2) Rate #2: A service that reimburses for the costs of registration/conference training fees, books and supplies associated with the training and support needs. Note: The daily maximum applicable to the unit service rate #1 above is not applicable to this non-hourly, reimbursement of cost of training service rate #2. For example, the unpaid caregiver may be approved to attend a conference to receive training on how to address her child's behaviors. It does not matter if the conference is 12 hours per day and exceeds the maximum hours limit of rate #1, as only the cost of the actual training is reimbursed to the care giver for their attendance at the training. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Non-Medical Transportation - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Rate: Unit Rate – Driver with Vehicle – This code is limited to a flat rate per round-trip of one (1) unit. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Community Transition Services - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.

	Supported Education - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Pre-Vocational Training - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.
	Benefits Planning - The rates were established by comparing the services to similar covered Medicaid services. Medicaid will pay the lower of billed charges or fee schedule established by the state agency. Payment to private and non-state governmental providers will be based on the lower of billed charges or the fee schedule established by the state agency. Payment to state government providers will be based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted annually by state government providers. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

● No. Does not apply. State does not cover optional categorically needy groups.

Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

OTHER (*describe*):

(b) Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number).*