North Dakota – Department of Justice Settlement Agreement

Draft Biannual Report
December 14, 2023 – December 13, 2024

ND Department of Human Services
Aging Services Division

Submitted February 1, 2025

List of Acronyms

ADA – Americans with Disabilities Act
ACL – Administration for Community Living
ADRL – Aging and Disability Resource Link
ARPA – American Rescue Plan Act of 2021
CAPABLE - Community Aging in Place, Advancing Better Living for Elders
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR- Critical Incident Report
CQL – Council on Quality and Leadership
CtLC – Charting the LifeCourse
CSC – Community Services Coordinator
DD – Developmental Disabilities
DHHS – Department of Health and Human Services
EPCS – Extended Personal Care Services
Ex-SPED – Expanded Service Payments to the Elderly and Disabled
FTE – Full Time Equivalent
FMAP – Federal Medical Assistance Percentage
HCBS – Home and Community Based Services
HCBS waiver – HCBS Medicaid waiver
HSRI – Human Services Research Institute
HTP – Housing Transition Plan
IP – Implementation Plan
LCA – Local Contact Agent
LTSS OC – Long Term Services and Supports Options Counseling
MFCU – Medicaid Fraud Control Unit
MFP – Money Follows the Person
MFP-TI – Money Follows the Person Tribal Initiative
MSP-PC – Medicaid State Plan Personal Care Services
NCAPPS – National Center on Advancing Person-Centered Practices and Systems
NCI – National Core Indicators
NCI-AD – National Core Indicators – Aging and Disability
ND – North Dakota
NDAC – North Dakota Administrative Code
NDHFA – North Dakota Housing Finance Agency
NF LoC – Nursing Facility Level of Care
OAA – Older Americans Act
PCP – Person Centered Plan
PSH – Permanent Supported Housing
QSP – Qualified Service Provider
QSP Resource Hub – Qualified Service Provider Resource Hub
RA – Rental Assistance
SA – Settlement Agreement
SME – Subject Matter Expert
SNF – Skilled Nursing Facilities
SPED – Service Payments to the Elderly and Disabled

TBI - Traumatic Brain Injury
TPM – Target Population Member
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

On December 14, 2020, the State of North Dakota (ND) entered into an eight-year Settlement Agreement (SA) with the United States Department of Justice (USDOJ). The SA is designed to ensure that the State will meet the requirements of Title II of the Americans with Disabilities Act (ADA).

The SA requires the State to submit biannual reports to the USDOJ and the Subject Matter Expert (SME) containing data according to the Implementation Plan (IP). The initial IP was approved on September 28, 2021, as required in the SA.

This report describes progress toward the requirements listed in Sections VI–XVI for December 14, 2023 through December 13, 2024. The report builds on the approved SA IP. All the requirements and associated strategies toward compliance that were due or are being worked on in this reporting period are included. New information is provided under the progress report heading highlighted in yellow and target dates were modified when necessary.

A reporting dashboard of the activities conducted in this reporting period are included as Appendix A, Link to 2024 Aging Services DOJ SA Dashboard to this report. They provide statistical data and additional information about the progress that has been made toward the required benchmarks of the SA regarding LTSS Option Counseling home and community-based services (HCBS), Aging and Disability Resource Link (ADRL), transition support services, and housing to assist target population members (TPM).

The State created a Year 1 and Year 2 comparison dashboard that highlights the progress and data trends since the SA was signed on December 14, 2020.

Link to Aging Services Annual Comparison Dashboard

A complaint report is included in Section XVI (Appendix E) of this document as required. It includes a summary of the type of complaints received and remediation steps taken to resolve substantiated complaints involving TPMs that were submitted during this reporting period.

The strategies contained in the IP and the performance measures and statistical data in this report focus on the need to:

- **Increase access** to community-based service options through policy, process, resources, tools, and **capacity building** efforts.
- Increase **individual awareness** about community-based service options and create **opportunities** for LTSS Options Counseling.

- Widen the **array of services** available, including more **robust housing-related supports**.

- Strengthen **interdisciplinary connections** between professionals who work in behavioral health, home health, housing, and HCBS.

- Implement broad access to **training and professional development** that can support improved **quality** of service, highlighting practices that are **culturally informed**, streamlined, and rooted in **person-centered** planning.

- Support **improved quality of care** across the array of services in all areas of the State.

- Improved **QSP enrollment experience** which has led to increasing **QSP recruitment and retention.**

What We're Proud of

Major accomplishments during Year 4 (December 14, 2023 – December 13, 2024) of the USDOJ SA:

- **Transitioned 139 TPMs** from a SNF to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.

- **Diverted 390** new individuals from a SNF by providing necessary services and supports so they can remain at home with their family and friends.

- Provided **information about HCBS** options through **1,193** unduplicated LTSS Options Counseling referral visits to **1,151** unduplicated TPMs referred for a long-term stay in a SNF.

- There are **2,147** (October 2024) current Medicaid recipients residing in SNFs. There were **856 unduplicated** annual LTSS OC visits in SNFs during this reporting period.

- Provided **centralized intake** using the Aging and Disability Resource Link (ADRL) website and toll-free phone line linking people with disabilities to HCBS support.

    - Provided **16,226 callers** with information and assistance about HCBS and assisted another **1,641** through the **web intake** process**.**

    - Referred **1,470 individuals** from these contacts for **HCBS**, which is an average of **123** per month.

- HCBS Case Managers responded to **1,807 HCBS referrals** from all sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit, and LTSS Options Counseling visits).

- Provided State or federally funded HCBS to **3,586 unduplicated** adults in this reporting period.

- Provided **permanent supported housing** assistance to **51 (both TPM and MFP rental assistance) TPMs** who transitioned out of a SNF.

- **Increased awareness** about the possibilities of in-home and community-based services for adults with physical disabilities through numerous presentations, conferences, and training events.

- Engaged with **stakeholders** to inform the strategies used to implement the requirements of the Settlement Agreement in a person-centered and culturally responsive way.

Lessons Learned – An end of Year 4 perspective.

As we conclude Year 4 of the settlement agreement (SA), the demand for Home and Community-Based Services (HCBS) has never been higher, increasing the workload for HCBS Case Managers and State staff. There has been a 54% increase in the number of HCBS participants served since 2020 when the SA was signed. The increased demand in services has resulted in the need for more HCBS case managers. On average, 150 new referrals and 80 new cases opened for HCBS each month. Last year 3,586 individuals were served under HCBS. To help manage caseloads, the State has hired three (3) additional HCBS case managers and one (1) Basic Care case manager. In the coming months, four (4) more HCBS case managers (including two nurse case managers) will be added to further support the growing need. The State is also planning to hire another Complaint and Grievance administrator and an Assistant Director for the Adult and Aging Services Section.

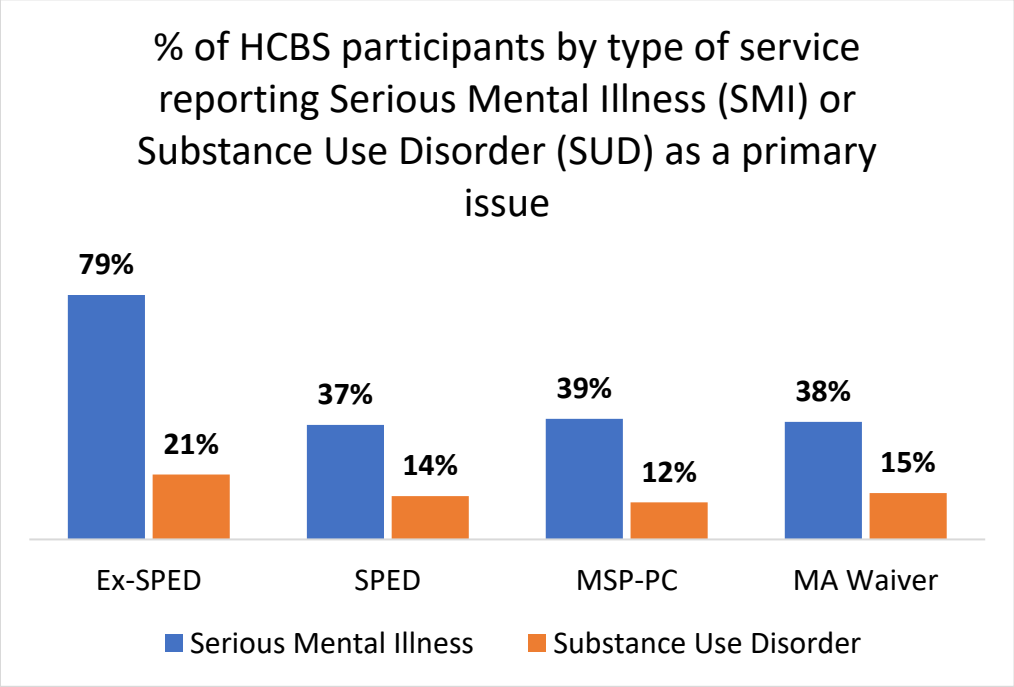
With more individuals utilizing HCBS, the demands on State program administrators and fiscal staff are also increasing. The preference for in-home care remains strong and is expected to grow as the baby boomer generation ages. According to the ND State Data Center, North Dakota's 65+ population, currently about 18% of the total population, will increase by approximately 3,000 people by 2035. While a slight decline is projected between 2035 and 2045, growth in the 85+ population is expected to resume thereafter.

The Administration for Community Living estimates that seven (7) in ten (10) individuals will require long-term services and supports (LTSS) for at least five (5) years. A primary challenge for all states is ensuring adequate funding, case management, provider capacity, program administration, and accessible, affordable housing to meet this demand. While serving individuals in the least restrictive setting (typically a private or family home) remains a top priority, it is increasingly complex due to the rising number of current and future TPMs.

An additional challenge is the growing number of TPMs who require care not only for physical disabilities but also for complex medical and behavioral health needs. Many

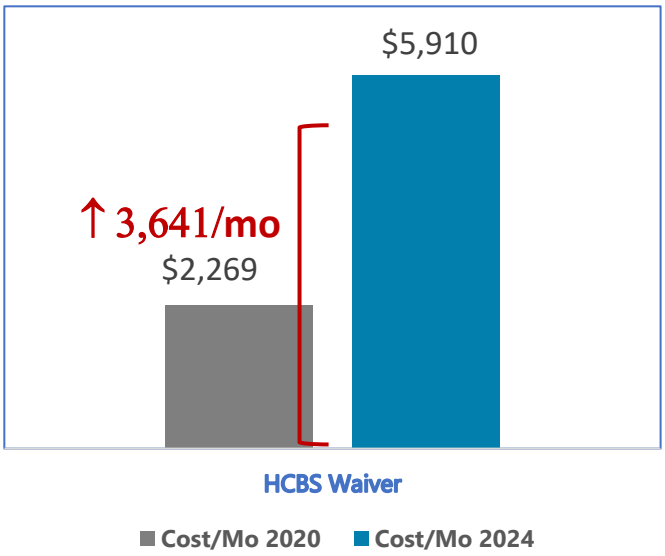
individuals receiving services under the HCBS waiver are completely dependent on human assistance for daily activities such as bathing, dressing, and meal preparation, as well as instrumental activities like shopping and housekeeping.

The chart below illustrates the number of HCBS recipients diagnosed with a serious mental illness or substance use disorder by HCBS program in 2024. Additionally, many individuals have complex medical conditions caused by paralysis, chronic obstructive pulmonary disease (COPD), heart failure, and Type 2 diabetes, some of the most common diagnoses among HCBS recipients.



These complex medical needs have driven increased demand for services such as extended personal care, nurse education, residential habilitation, and community supports. As demand rises, so do the costs, particularly for services provided under the HCBS waiver.

From 2020 to 2024, the average monthly per person HCBS waiver costs grew by 160%. The chart below illustrates that growth.

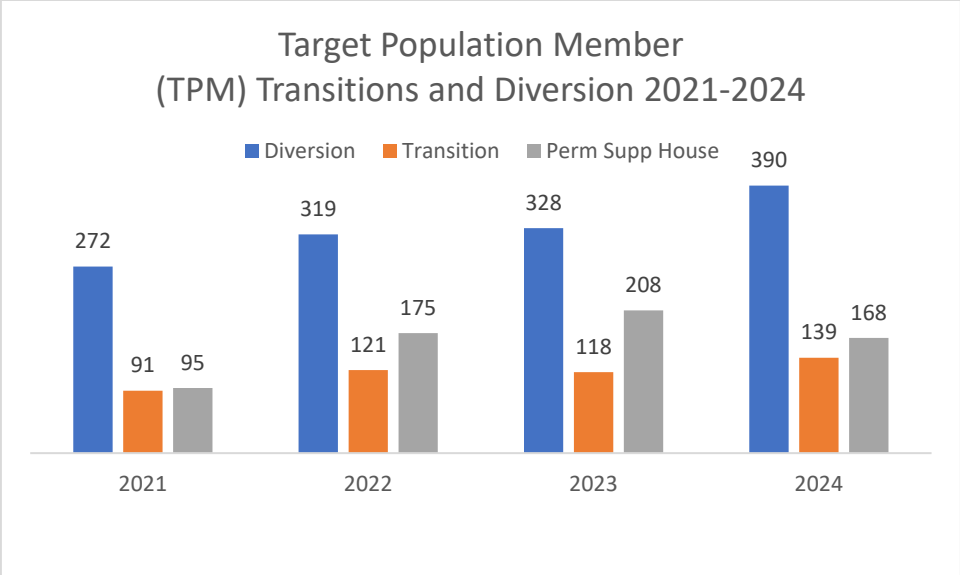


The growth can be attributed to three key factors: the availability of 24-hour delivery of complex care, the increasing prevalence of serious mental illness and substance use disorders, and the rising number of HCBS recipients with complex medical needs.

These challenges have also created a growing demand for highly trained providers who understand the specialized care required to support individuals in the community. To address this, the State has included a targeted rate increase in the Executive Budget Request to attract more providers, particularly nurses, who are willing to serve individuals in home and community-based settings. Additionally, the Year 5 IP outlines strategies to enhance provider training and support to ensure high-quality in-home services.

The new provider enrollment portal has transformed the application and approval process for agencies and individuals willing to enroll to provide State and federally funded HCBS. The web-based platform is used to help QSPs enroll, revalidate, and make provider updates. As a result, the State enrollment team can now process applications in less than 14 days, significantly reducing the time between HCBS eligibility determination and service delivery. The State did not consistently track processing time in the old system, but some providers reported that it took up to 6 months to get an application approved using the old process. These system enhancements have also contributed to higher QSP retention rates each year.

The State is successfully transitioning and diverting more TPMs than ever before. Since the start of the SA, the State has completed **469 transitions, 1,309 diversions, and 646 permanent supported housing placements**. The chart below illustrates these efforts and underscores the critical role that permanent supported housing plays in ensuring successful TPM transitions.



The State continues to collaborate with the Centers for Independent Living (CILs) to enhance resources and training for transition coordinators, ensuring the delivery of high-quality, efficient, and effective transition coordination services. Additional resources have also been allocated to Minot State for housing facilitators, who play a vital role in helping individuals secure affordable, accessible housing across the State.

Efforts remain underway to fully implement all projects funded by the MFP Capacity Fund and the ARPA of 2021 Section 9817 10% enhanced FMAP proposal, as approved by CMS. These additional funds have been instrumental in the progress made toward meeting the settlement agreement requirements. However, since the funds must be expended by December 31, 2025, the State is working within a limited timeframe to complete as many projects as possible.

Additionally, the State has begun documenting key achievements related to the system change efforts that have been implemented in response to the SA requirements. In collaboration with a marketing firm, case studies have been developed to showcase the most successful aspects of system change efforts and their impact on individual TPMs. These case studies, which include testimonials from actual TPMs, are attached to this report. The project has also produced high-quality videos featuring TPMs who have shared their experiences in accessing HCBS, with the goal of inspiring others. These videos can be viewed on the Department's website. Link to videos

The State believes there should be no question that North Dakotas response to the SA has created an HCBS system that provides TPMs, even those who need the highest level of care (24-hour individual support) an opportunity to live in the most integrated setting that meets their needs.

The State is committed to continue to serve TPMs and will continue to work on solutions to challenges that still exist. They include:

- Creating a flexible fee for service delivery system that allows providers to react to

the ever-changing needs of older adults and adults with physical disability i.e., frequent hospitalizations, request to change providers, etc., while ensuring compliance with federal and state requirements.

- Complex billing and claim correction rules as well as EVV requirements have made providing care and billing for these services much more challenging. Some providers lack the expertise or desire to manage all these complex systems and choose to only work with the private pay market. Reform needs to happen at the federal and state level to remove some of the bureaucratic barriers that inhibit creativity and flexibility in the service delivery and payment system, especially for Medicaid funded HCBS.

- Workforce issues continue to strain the service delivery system. The State has attracted a large amount of individual and agency providers, but gaps remain for TPMs who can't find the right type of provider in their chosen community. In contrast, the eastern part of the state has a high concentration of providers, leading to competition for referrals. Many providers still report difficulties in recruiting staff for 24/7 care situations.

- Other challenges include the need to improve the quality of HCBS especially for those with complex needs.

Looking Ahead

A Year 5 IP was recently approved. During Year 5 of the US DOJ SA the State intends to:

Support QSPs

- Finalize the Connect to Care marketing features.

- Provide behavioral health training to enhance QSPs' ability to serve individuals with complex needs.

- Offer personal resilience training to support QSPs in managing caregiving demands.

- Implement targeted rate increases, pending approval in the 2025-2027 Health and Human Services budget.

- Recruit providers willing to serve individuals with complex needs.

- Enhance the QSP Enrollment Portal and refine services provided by the QSP Hub.

Divert TPMs from Institutional Stays

- Assess the need for additional case managers and program staff to support the growing demand for in-home and community-based services.

- Complete the implementation of projects funded by the Federal ARPA 9817 plan to strengthen the HCBS infrastructure.

Facilitate TPM Transitions to Integrated Settings

- Integrate peer support into the transition team model.
- Focus on independent living skills to help TPMs adapt to community living.

Expand Permanent Supported Housing

- Maximize State and federal resources to provide rental assistance for TPMs.
- Build partnerships with the construction and remodeling industry to improve access to environmental modifications, helping TPMs maintain stable housing.

Year 5 Settlement Agreement Requirements (12/14/24-12/13/25)

The chart below lists the requirements from the Settlement Agreement (SA) that are due during Year 5 of the settlement agreement. The State believes that all Year 4-year requirements have been met except for transitioning TPMs within 120 days. The State works with TPMs to create safe and efficient transition plans and the goal is to transition people within the 120-day requirement. However, many TPMs have significant barriers to overcome like declining health, need for additional therapy, and specific housing needs that can make meeting this goal very difficult. The State has recently discussed ways State staff can assist the transition teams to take specific action to resolve reoccurring issues that may be unnecessarily delaying a transition.

SA Section #	Requirement	Due Date
VI.F	Develop an Implementation Plan for Year 5	12/23/2024
XIII.D	Provide technical guidance to SNFs that commit to provide HCBS and rural community providers who commit to expand	Ongoing requirement
XV.D	Submit State Biannual Data Reports -	2/1/2025 and 8.1.25
XIV.A 1.	Conduct individual or group in-reach to each nursing facility	Completed annually
VIII.I 2.	Person-centered planning training of Case Managers	Completed annually

X.B.2.	Implement incremental changes to the NF LoC process and community-based services eligibility	06/14/2022 and ongoing
X.B.3.	Require annual NF LoC determination screening for all continued stay in a nursing facility for TPMs.	12/14/2022 and ongoing
XI.B	Transitions occur no later than 120 days after TPM chooses (See Note above)	06/14/2022 and ongoing
XV.D	Submit year 6 IP	11/1/2025
XV.D	State Biannual Data Report	01/31/26

SA Section VI. Implementation Plan

Responsible Division(s)

ND Governor's Office and ND Department of Health and Human Services (DHHS) Aging Services.

Agreement Coordinator (Section VI, Subsection A,B, & C pages 8-9)

Nancy Nikolas Maier has been appointed as the Agreement Coordinator. Michele Selzler is the Settlement Agreement Support Specialist. The State holds regularly scheduled internal meetings to review progress toward implementing the strategies included in the IP and to develop new strategies that will assist the State with implementing the requirements of the SA.

Service Review (Section VI, Subsection D, page 9)

Implementation Strategy

Continue to conduct internal and external listening sessions that include a review of relevant services with stakeholders and staff from the ND DHHS Aging Services, Medical Services, Developmental Disability, and the Behavioral Health Division. One priority is identification of administrative or regulatory changes that need to be made to reduce identified barriers to receiving services in the most integrated setting appropriate.
(Ongoing strategy)

Progress Report:

A listening session is conducted during every ND USDOJ SA stakeholder meeting. Feedback is used to modify policy and waiver amendments. The State will continue to hold listening-sessions in future years of the agreement. Link to 2024 Listening Session Summary

Based on the feedback provided during these events the State took the following actions.

- Regarding the gap in programming for younger people with disabilities the State added companionship to SPED for the under 60 population.
- In response to the information about various tax breaks for adults with disabilities and older adults, the State is planning to have the Tax Department conduct a webinar explaining how these programs work.
- We are working with a group of SMEs from the Tribal Nations to address the needs of Native Americans. The group worked together to add care coordination as an allowable task under the HCBS waiver. In addition, an amendment to the TCM state plan has been submitted to make it easier for qualified staff from Tribal nations to provide this service.
- Interest was expressed in additional incentive grants for QSPs. The State has submitted a request to CMS to allow the State to issue grants that would improve transportation for TPMs to medical appointments and other community services.
- The group expressed the need for continued housing assistance. The 25-27 biennium executive budget request includes $300,000 in State general fund to provide rental assistance to TPM's.

Stakeholder Engagement (Section VI, Subsection E, page 9)

Implementation Strategy

Strategy 1. The State will continue to create ongoing stakeholder engagement opportunities including quarterly ND USDOJ SA IP stakeholder meetings through the years of the SA. The State will educate stakeholders on the HCBS array, receive input on ways to improve the service delivery system, and receive feedback about the implementation of the SA. The State asks for feedback on a variety of topics, shares data and allows time for attendees to share any issues they feel need to be addressed at each meeting. A Stakeholder feedback summary will be completed at the end of the year. **(Ongoing strategy)**

2025 Meeting Schedule:

- March 20, 2025
- June 12, 2025

- September 18, 2025
- December 11, 2025

Strategy 2. The State will continue to work with community partners to hold in-person HCBS Community Conversations in rural and frontier areas of the state including Native American reservation areas in ND. These meetings are different from the DOJ stakeholder meetings and generally focus on the HCBS needs of one community or area of the State. The State will target small communities who lack LTSS options and discuss ways that services can be developed in these hard to serve areas. The meetings will provide information about HCBS and provider enrollment and will include an opportunity to receive valuable feedback from local community stakeholders about the provision of HCBS in rural and Native American communities. The State will post meeting dates on a calendar of events section on the DOJ portion of the DHHS website and create a summary of stakeholder feedback at the end of the year. The State will utilize the feedback provided to inform how the State will implement changes to the service array, simplify administration and increase access to HCBS. Invitations to these events are sent to hospitals, SNFs, CILs, QSPs, social service agencies, State staff, advocates, and local community leaders. **(Ongoing Strategy)**

Community Presentations from December 14, 2023 - December 13, 2024

Month/Year	Location	# Attendees	Group	Virtual	In-person
January 2024	Fargo	47	6 Low Income Housing Sites		x
	Dickinson	1	Long-term Care		x
	Minot	8	Trinity Hospital		x
February 2024	Williston	4	Dementia Café Group		x
March 2024	Wahpeton	11	Border States Aging Fair		x
	Fargo	12	Low Income Housing		x
April 2024		28	Behavioral Health Council	x	
	Minnewaukan	35	Benson County 55+ Club		X
		9	Powerful Tools for Caregivers	x	
May 2024	Bismarck	50	United for Hope Cancer Walk		X
	Bismarck	25	LTC Conference		X
	Bismarck	15	Community Elder Service Network		X
	Bismarck	60	YMCA Senior Health Fair		X
	Wahpeton	193	Wahpeton Senior Center Aging Expo		X
	Grand Forks	50	Service Providers Fair		X
June 2024	Fargo	370	Memory Care Conference		X
	New Salem	20	Health Fair		X
	Moorhead, MN	50	Connecting the Caregiver Conference		X
	Medora	100	West River Conference on Social Welfare		X

July 2024	Fargo	25	Memory Care of the Red River Valley		X
	Arthur	30	Community of Care Health Fair		X
	Bismarck	10	Dakota Community for Independent Living Walk		X
	Belfield	9	Belfield Senior Center		X
August 2024	Bismarck	15	AARP Caregiving at Home		X
	Bismarck	10	Law Enforcement and SWAT Negotiation Team		X
September 2024	Moorhead, MN	75	Senior Safety Academy		X
	Bismarck	40	Parkinson's Conference		X
October 2024	Casselton	170	Casselton Senior Day		X
November 2024		7	Alzheimer's Association Staff	x	

Strategy 3. Include representation from New Americans and other special groups when gathering public input. The State will continue to work with the UND Native American Resource Center staff to hold a monthly stakeholder call with experts from Tribal entities to guide the public input and stakeholder engagement process as it relates to Native American elders and individuals with disability. This group will also be consulted to help identify local subject matter experts who may be willing to provide cultural awareness training with State staff and others who work in Tribal communities in ND. **(Ongoing Strategy)**

Progress Report:

The State is currently working with advocates from the LGBTQIA+ community and will reach out to the Department's refugee services coordinator to determine the best way to reach the New American, migrant, and refugee population in ND to ensure they are included in future stakeholder meetings.

The Native American stakeholder call, held in collaboration with staff from the UND Resource Center, convened monthly throughout Year 4 of the settlement agreement. The group successfully added care coordination as an allowable billable task under the HCBS Medicaid waiver. Additionally, they updated the qualifications for providing Targeted Case Management to tribal members and individuals eligible for Indian Health Services to include lived experience.

SME Consultation and IP (Section VI, Subsection F & G, page 9)

Implementation Strategy

Agreement Coordinator will meet weekly with SME and team to consult on IP. Agreement Coordinator will provide required updates to USDOJ, submit drafts, and incorporate

updates as required. The revisions to the IP will focus on implementation for the upcoming year, challenges encountered by the State to date, and strategies to resolve them with plans to address noncompliance if required. **(Ongoing strategy)**

Website (Section VI, Subsection H, page 10)

Implementation Strategy

Maintain a webpage for all materials relevant to ND and USDOJ SA on the DHHS website. The plan and other materials are made available in writing upon request. A statement indicating how to request written materials is included on the established webpage found here https://www.hhs.nd.gov/adults-and-aging/us-department-justice-settlement-agreement. **(Ongoing strategy)**

Section VI. Performance Measure(s)

Number of unduplicated individuals served in HCBS by funding source.

- During this reporting period there were 3,586 unduplicated individuals served under SPED, Ex-SPED, Medicaid waiver, and MSP-PC.
  - SPED – 1,871
  - Ex-SPED – 70
  - Medicaid Waiver – 851
  - MSP-PC - 794

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

Role and Training (Section VII, Subsection A, page 10)

Implementation Strategy

Updated Strategy 1. The State will employ HCBS case managers who will provide HCBS case management full time. The State will require all newly hired HCBS case managers to complete a comprehensive standardized training curriculum that has been developed within three (3) months of employment. The State will provide ongoing training and professional development opportunities to include cultural sensitivity training for special populations to ensure a high-quality trained case management workforce. The State will continue to work with Tribal stakeholders to identify local experts in Native American

cultural competency to develop and deliver training for HCBS case managers. Post-training evaluation tools to ensure understanding of training objectives will be developed. **(Ongoing strategy)**

Challenges to Implementation

The State will work with NCAPPS to develop a process to objectively measure increased cultural awareness.

Progress Report:

See implementation strategy in Section VIII, Subsection H, page 13 for additional information.

To ensure annual ongoing training, the State will use MFP capacity building funds to procure an entity to provide ongoing technical assistance and annual person-centered planning training through September 30, 2025. Training will be required for all HCBS case managers and DHHS Aging Services staff. The full development of the PCP competency training learning modules, hands on learning, train the trainer, and evaluation of competency components is complete. This curriculum was completed by most of Aging Services staff by December 13, 2024. New hires will be required to complete the training in the first 12 months of employment with Aging Services. The feedback from staff was mostly positive. The team expressed that the training allowed them to think deeper about what it means to be person centered and how they can apply it to their current work.

In 2025 the State will implement the “Train the Trainer” portion of the curriculum throughout Aging Services. The State is considering using federal 9817 funds to hire a temporary staff person with an education degree and experience in adult learning to teach the train the trainer curriculum to Aging Services staff.

In 2025, the workgroup that was responsible for developing the PCP training competencies will meet again to determine the best way to roll this out. Aging Services supervisors and mentors will be trained and implemented in the Indicators of Competency and Evaluating Competency in Person-Centered Planning. **(Updated target completion date December 31, 2025)**

Updated Strategy 2. The State employs two provider navigators who will assist all HCBS case managers state-wide in finding QSPs to serve eligible HCBS recipients. The State will consider the feasibility of using the new Connect to Care system formally referred to as ConnecttoCareJobs platform to share referrals for HCBS to QSPs. This will free up time for the case managers and assist them in keeping up with the increased demand for HCBS**. (Target completion date August 1, 2025 and ongoing)**

Progress Report

The State will continue to use the provider navigators to assist individuals in finding a provider wo meets their needs. The State has decided not to purse using ConnecttoCare jobs as a referral service because the current process is working. The system will still be used as a marketing tool for QSPs who are looking for clients.

Updated Strategy 3. To ensure a sufficient number of HCBS case managers are available to assist TPMs in learning about, applying for, accessing, and maintaining community-based services for the duration of the SA, the State will continue to monitor weighted caseloads of the 68 licensed social workers currently hired as HCBS case managers. The State will also monitor the caseload impact of moving all the Basic Care cases to three (3) specialized basic care case managers. **(Target completion date April 1, 2025 and ongoing)**

Progress Report:

In November 2024, an additional three (3) new HCBS case managers were hired, and one (1) new Basic Care case manager was hired. and the current average weighted caseload is 117. At this time there are 73 total case managers that includes 61 full-time, 12 part-time, and eight (8) supervisors who carry a small caseload. The State's ideal goal for weighted caseload is between 100-110 per case manager.

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

Ensure that the supervisors are assigning the case manager to TPMs already living in the community and requesting HCBS within two (2) business days. **(Ongoing strategy)**

Progress Report:

The current average time for cases to be assigned to a case manager is two (2) days.

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

Strategy 1. Continue to ensure a sufficient number of HCBS case managers are available to serve TPMs. The State assigns caseloads to individual HCBS case managers based on a point system that calculates caseload by considering the complexity of case and travel time necessary to conduct home visits. The State completes a monthly review of statewide caseloads to determine capacity and ensure a sufficient number of HCBS case managers are available to serve TPMs. **(Ongoing strategy)**

Challenges to Implementation

The volume of ADRL referrals, visit requests, and interest in HCBS in general remains high. The State has increased the number of case managers available to serve this population and will continue to monitor the need for additional staff.

Remediation

The State will continue to monitor the need for additional HCBS case managers. The goal is to have a weighted caseload of no more than 100 cases per case manager **(Ongoing strategy)**

Progress Report:

See Section VII.A. Updated Strategy 3

Access to TPMs (Section VII, Subsection D, page 11)

Implementation Strategy

Strategy 1. Address issues of affording case managers full access to TPMs who are residing in or currently admitted to a facility. Facilities that deny full access to the facility will be contacted by the Agreement Coordinator to attempt to resolve the issue and will be informed in writing that they are not in compliance with ND administrative code or the terms of the Medicaid provider enrollment agreement. If access continues to be denied, a referral will be made to the DHHS Medical Services Program Integrity Unit which may result in the termination of provider enrollment status. **(Ongoing strategy)**

Progress Report:

No case managers were denied full access to SNFs during this reporting period.

Updated Strategy 2. Conduct training with hospital and SNF staff to discuss HCBS, LTSS Options Counseling, facilitate case management for TPMs, and the required annual level of care screening. The training will be adjusted over time to reflect further changes to the NF LoC process and to address any emergent issues and may be provided virtually. **(Ongoing strategy)**

Challenges to Implementation

Additional training to ensure new hires and existing staff are continuously aware of the LTSS Options Counseling process and the requirement for HCBS case manager access in the SNF.

Remediation

Training will be held at least biannually (every two (2) years) in Year 4 of the Settlement Agreement. **(Target completion date December 13, 2024)**

Progress Report:

See Section VII. Performance Measures

Strategy 3. Utilize the educational materials created to inform TPMs, family, and legal decision makers of the requirements of the SA, LTSS Options Counseling, ongoing case

management for SNF TPMs, and that TPMs must complete an annual NF LoC determination. **(Ongoing strategy)**

Progress Report:

There were 75 annual SNF presentations completed in 2024 with 895 individuals in attendance.

Case Management System Access (Section VII, Subsection E, page 11)

Implementation Strategy

Provide HCBS case managers and relevant State agencies access to all case management tools including the HCBS assessment and PCP. Work with the case management vendor to continue to refine and improve the user experience for staff. Simplification projects include updating the individual home page for HCBS case mangers so they can better navigate through their HCBS assessments, PCPs, and provider authorizations. The State will continue to monitor caseloads and will ask for additional staff if warranted in the next budget request. **(Target completion date December 13, 2025 and ongoing strategy)**

Progress Report:

All required staff have access to the case management system. This includes Aging Services case management, ADRL intake, Community Service Coordinators, LTSS OC, VAPS investigators, Housing Facilitators, and Transition Coordinators. Tribal entities that enroll to provide care coordination and targeted case management to tribal members of individual eligible for Indian Health Services will also be provided access to the case management system.

Quality (Section VII, Subsection F, page 11)

Updated Implementation Strategy

To ensure a quality HCBS case management experience for all TPMs the State will conduct annual case management reviews to ensure sampling of all components of the process (assessment/person-centered planning/authorization/safety, contingency plans, and service authorizations) to determine if TPMs are receiving services in the amount, frequency, and duration necessary for them to remain in the most integrated setting appropriate. The State can now identify which consumers are TPMs so the audit information will be updated to include data about TPMs. **(Ongoing strategy)**

Progress Report:

Case management audits, quality assurance, and continuing education for each territory and case managers are completed by December 31st of each year. The report indicates

the type of errors, and each case manager is trained individually. Twice per year, State program administrators meet with staff in each case management territory to review all errors. Link to Appendix B - 2024 Case Manager Reviews/Audit Summary

ADRL (Section VII, Subsection G, page 11)

Implementation Strategy

The strategies listed in Section VII.A. also apply to this section.

Section VII. Performance Measure(s)

The State will compile individual audit data into an annual report and will measure the case management requirement error rate by territory and type.

Total number of HCBS case managers serving Tribal nations.

- There are 15 HCBS Case Managers who serve eligible individuals who reside in reservation communities.

Number of SNF and hospital staff trained in NF LoC procedures/LTSS Options Counseling/discharge planning.

- 116 professionals were reached in eight (8) in person trainings across the state and one virtual opportunity.
    - Bismarck – October 8, 2024
    - Minot – October 8, 2024
    - Williston – October 9, 2024
    - Dickinson – October 9, 2024
    - Jamestown – October 15, 2024
    - Devils Lake – October 15, 2024
    - Grand Forks – October 16, 2024
    - Fargo – October 16, 2024
    - Virtual session – November 5, 2024

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Updated Implementation Strategy

State staff, public, private, and tribal HCBS case managers will continue to use the fully implemented case management system that includes Charting the LifeCourse person-centered planning framework tools. HCBS case managers will create, with the TPM, the PCP that will be maintained and updated in the system.

The State will also continue to work with Human Service Research Institute (HSRI) and LifeCourse Nexus University of Missouri Kansas City Institute for Human Development and stakeholders to finalize the person-centered planning competencies and corresponding training. A sustainable training and staff development program will be part of initial onboarding and ongoing professional development practices to support the core competencies of all Aging Services Division staff and providers. Outline of competencies and training is projected is finalized, with the updated training to meet competencies held throughout 2024. **(Ongoing strategy)**

Progress Report

See response in Section VII. Subsection A. Strategy 1.

Policy and Practice (Section VIII, Subsection B & C, page 11)

Implementation Strategy

Every PCP will incorporate all the required components as outlined in Section VIII.C.1-8 of the Settlement Agreement and these are apparent in PCP documentation. The person-centered planning tool in the case management system will allow all required information to be captured and included in the plan. The PCP will be updated when a TPM goes to the hospital or SNF and remains available and accessible in the system when the TPM returns to the community.

During the annual case management review process the State will review sample PCPs from each HCBS case manager to ensure they are individualized; effective in identifying, arranging, and maintaining necessary supports and services for TPMs; and include strategies for resolving conflict or disagreement that arises in the planning process. **(Ongoing strategy)**

Progress Report:

See Section VIII. Performance Measures

Person-Centered Planning Policy (Section VIII, Subsection D and E, page 12)

Implementation Strategy

Current policy requires that when a TPM applies for long-term services, the HCBS case manager or the MFP transition coordinator initiates the person-centered planning process. The person-centered planning process policy also includes resolving conflicts that may arise during the process and informing TPMs that they may obtain a second opinion from a neutral healthcare professional about whether they can receive HCBS. **(Ongoing strategy)**

Progress Report:

There have not been any TPMs who requested a second opinion from a neutral health care professional in this reporting period.

Reasonable Modification Training (Section VIII, Subsection F, page 13)

Implementation Strategy

To comply with Title II of the ADA which states that a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity, the State will work with the DHHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification can be accommodated as required in the SA. **(Ongoing strategy)**

Challenges to Implementation

TPMs, HCBS case managers, and other stakeholders may not understand reasonable modification as required under Title II of the ADA.

Remediation

The State will continue to conduct annual training with HCBS case managers and stakeholders to increase knowledge and awareness of how to identify and notify the Department that an individual has an anticipated or unmet community service need so that the State can determine whether, with a reasonable modification, the need can be met. The State will continue to track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity.

Progress Report:

There have been 78 case managers trained on ADA and reasonable modifications. Additionally, all new case managers are trained on ADA requirements and reasonable modification within the first three (3) month of hire. The ADA and reasonable modification

training is required for all case management staff to include: 73 HCBS Case Managers, 4 Basic Care Case Managers, and 10 Long-Term Service and Supports Options Counselors. Eight (8) Case Managers have been assigned the annual training to complete upon return to work and one (1) Case Manager position was vacant at the time of the annual training. Any staff who are in the process of completing the training are closely monitored to ensure the training is completed.

SME review of Transition Plans (Section VIII, Subsection G, page 13)

Implementation Strategy

Updated Strategy 1. The State will inform the SME that a setting other than the TPM's home, a family home, or an apartment was chosen as the TPM's most integrated setting appropriate to meet their needs when the State intends to count the transition to the site to meet the requirements of the SA. Information about the number of TPMs who moved to another type of setting will also be included in the biannual report. **(Ongoing Strategy)**

Progress Report:

See Section VIII. Performance Measures

Person-centered planning TA (Section VIII, Subsection H, page 13)

Implementation Strategy

To ensure annual ongoing training, the State will utilize MFP capacity building funds to procure an entity to provide ongoing technical assistance and annual person-centered planning training through September 30, 2025. Training will be required for all HCBS case managers and DHHS Aging Services staff. The entity continues to assist the State in developing person-centered planning policy and procedures, performance measures, and core competencies that will assist the TPM in receiving services in the most integrated setting appropriate. The entity and State will also be developing a train-the-trainer program for person-centered competencies, learning modules, and hands on learning. Supervisors of State staff will learn how to determine staff competency and will learn ways to remediate any gaps in knowledge identified through the process. **(Updated target completion date December 31, 2025)**

Progress Report:

The purpose of the AASD Person-Centered Competency Training Series is to provide a sustainable training and staff development program that combines instructional and experiential learning as a part of initial onboarding, and ongoing professional development and performance management practices to support the core competencies for all Adult and Aging Services Section programs. The curriculum was developed through stakeholder engagement and workgroup processes that provided vital information and resources that was developed into five (5) training modules.

The North Dakota Adult and Aging Services Section Person-Centered Competency Training Series was developed in collaboration with the University of Missouri-Kansas City training, as sub-contracted by the Human Services Research Institute and NCAPPS and ND HHS, Adult and Aging Services Section. Five (5) modules have been developed in alignment with the National Center for Advancing Person-Centered Practices and Systems' competency domains for person-centered planning facilitation. Details for each module and the series as a whole are provided below.

Series Overview:
This series was developed to provide a foundational understanding of person-centered practices and skills for new human services staff across program areas; such as Home and Community Based Services Case Managers, Vulnerable Adult Protective Services, Long-Term Services and Supports, Ombudsman, ND Behavioral Health, Centers for Independent Living, and other stakeholder engagement. The series contains a mix of self-paced and asynchronous learning coupled with live/facilitated reflection sessions and trainings.

Module 1 is entirely self-paced, whereas Modules 2 and 4 were designed to be delivered live through a facilitator/trainer, and Modules 3 and 5 are hybrid with both self-paced and live learning. Reflection sessions are meant to reinforce topical learning received through the self-paced materials. They also provide an opportunity for discussion and activities that support new staff in applying concepts and connecting with their peers and coworkers.

Module Titles:
- Supporting the Person to Understand and Drive Services and Supports
- Building and Facilitating Teams with the Person at the Center
- Supporting the Person's Choice and Decision-Making
- Conflict Resolution
- Cultural Humility

UMKC and State have also developed a train-the-trainer program for person-centered competencies, learning modules, and hands on learning. Supervisors of State staff will learn how to determine staff competency and will learn ways to remediate any gaps in knowledge identified through the process. The train-the-trainer program is slated to rollout in 2025 and the training of supervisors to determine competency will roll out in 2026.

Person-Centered Planning process and practice (Section VIII, Subsection I, page 13)

Implementation Strategy

Through facility in-reach, community outreach, and increased public awareness of the ADRL and HCBS options, the State seeks to reach TPMs and assist them in receiving services in the most integrated setting appropriate.

By the end of Year 4 of the SA the State must conduct person-centered planning with an

additional 650 TPMs. At least half of the TPMs who receive person-centered planning each year will be SNF TPMs.

Strategy 1. Ensure that a PCP is completed with every TPM who requests HCBS and is still residing in the community. **(Ongoing strategy)**

Progress Report:

See Section VIII. Performance Measures

Strategy 2. The State has assigned a case manager to every SNF and Hospital in the State. The case managers assigned to the facility are required to visit TPMs in that facility and provide person-centered planning at least annually. **(Ongoing strategy)**

Challenges to Implementation

Sufficient staff and system capacity to complete case management assignments and the person-centered planning process.

Remediation

With the assistance of the NF LoC vendor the State has developed a monthly report that lists TPMs by facility and by their original NF LoC determination date. The information on the report will assist the case manager in knowing who needs to be seen each month in each facility. Having the information will create efficiencies by allowing staff to schedule multiple visits at the same facility on the same day. The report will help the State keep track of the TPMs and ensure all TPMs are eventually seen as required.

Progress Report:

See Section VIII. Performance Measures

Updated Strategy 3. To help ensure that HCBS case managers conduct person-centered planning in a culturally responsive way, the State will work with Dr. Jeremy Holloway, Director of Geriatric education at UND to provide training with pre- and post-tests to measure learning on the following subjects:

- Working with New American communities to serve adults with physical disabilities.
- Working with Native American communities to serve adults and elders with physical disabilities. (Potential speakers for this training will be based on recommendations from members of the Native American stakeholder engagement workgroup.)
- Cross-Cultural Communication in the Healthcare Workplace (Three (3) part series).

- Describe what is Cross-Cultural Communication.
- Understand why Cross-Cultural Communication is essential in the workplace.
- Determine how to take the first practical step to improved Cross-Cultural Communication in the workplace. **(All training was completed December 13, 2024. New staff are assigned training, and their progress is tracked through the State's learning management system to ensure they complete all required training.)**

Progress Report:

See Section VIII Performance Measures.

New Strategy 4. Develop one of the person-centered planning competency modules to address cultural humility and competency. All Aging Services staff will be trained and required to meet these competency standards. **(Ongoing strategy)**

Progress Report:

Training on Module 5: Cultural Humility took place in November 2024, which included two (2) self-paced learning modules and a facilitated discussion session. Staff are required to complete both self- paced modules and the facilitated discussion to receive full credit for completing the module. One hundred eight of one hundred forty-one Adult and Aging Services Section staff completed the training. Thirty-three staff are still working towards completion of the training. The training will be offered in 2025 for new staff and staff who were unable to attend the facilitated discussion sessions.

- 5.1: Exploring Cultures Respectfully
  - Learning in this module is meant to impact and increase the core competencies of:
    - Person-Centered Thinking and Values
    - Staff establish rapport and trust with the person and family while supporting them to identify their vision for services and supports.
    - Cultural Humility and Responsiveness
  - Staff engage with team members using an approach of respect and non-judgement of cultural differences, while practicing self-reflection.
  - Learning Objectives: Upon completion of this course, learners will be able to:
    - Define culture and cultural humility.
    - Understand intersectionality and multiple identities.
    - Implement quick-start suggestions for integrating cultural humility into

their lives and work.
    - Value self-directed learning and cultural humility as a lifelong practice.

- Key Topics/Summary:

    - This lesson provided an overview of the many dimensions of culture, explored the differences between cultural competence and cultural humility, introduced the concept of intersectionality, and offered learners practical suggestions for how to incorporate cultural humility into their work.

- 5.2: Personal Bias

    - Learning in this module is meant to impact and increase the core competencies of:

        - Cultural Humility and Responsiveness
        - Staff engage with team members using an approach of respect and non-judgement of cultural differences, while practicing self-reflection.

    - Learning Objectives: Upon completion of this course, learners will be able to:

        - Name the various types of bias that exist.
        - Explore personal biases and what leads to their beliefs.
        - Understand how personal bias may harm others.
        - Value self-directed learning to identify and challenge personal biases.

    - Key Topics/Brief Summary:

        - This lesson provided an overview of how to define, acknowledge, and address personal biases. It introduced learners to the social and environmental factors that influence personal biases and the potential harm (such as microaggressions) that can be caused when personal and societal biases impact the way we interact with others. The lesson also offered learners opportunities to reflect on their own personal biases and provided strategies to begin addressing biases in their day to day lives.

New Strategy 5. Ensuring access to interpretive services and translating informational materials into other languages.

The QSP enrollment portal will include tool tips in Spanish, French, Napali, Arabic, and Bosnian. Applicants who need an interpreter to assist them in enrolling as a QSP can call the QSP Hub who will utilize an interpreter service when providing enrollment support. **(Target completion date February 28, 2025 and ongoing)**

Progress Report:

The QSP Hub used Language Link 57 times during this reporting period. After removing calls with no answer, inquiries about other QSP support needs, and 1:1 language support with Therap/billing related topics, the QSP hub supported nine (9) individuals from start to finish with the enrollment support using the interpretation service. These providers also required additional interpretation support with next steps.

The tool tips have been translated into the five (5) languages listed above and will be added to the QSP enrollment portal by February 28, 2025.

Section VIII. Performance Measure(s)

Number and percent of transition plans that identify a setting other than a TPM's home, family home, or apartment.

- There were no MFP Transition plans that indicated a non-integrated setting.
- There were nine (9) DD SNF transition plans that indicated the TPM wanted to transition to a non-integrated setting of an ICF. The plans for these TPMs never indicated the individual wanted to transition into an integrated setting.

Number of HCBS case managers who meet core person-centered competencies within the required timeframe.

- 100% of the Case Manager completed the required training on person-centered planning in a culturally responsive way, with Dr. Jeremy Holloway, Director of Geriatric education, University of North Dakota.

Number and percent of PCPs reviewed during the State case management review that meet all Settlement Agreement requirements.

- All of the 147 (100%) of the PCPs reviewed met all Settlement Agreement requirements.

Number of denials for TPMs requesting HCBS, associated appeals, and outcomes.

- Denials are not tracked by TPM status therefore, the following numbers are based on all denials regardless of TPM status. This count is not unduplicated since the request is a broken down by month. There were 283 program denials during this reporting period.

HCBS Denials		
Month/Year Request	**Denial Reason**	**# of Denials**
December 14, 2023 – December 31, 2023	Functional Eligibility	2
	No Action/services pursued	1

	Unable to Determine Functional Eligibility/Did Not Cooperate	2
	100% Fee	2
	Not on Medicaid	2
January 2024	Proposed FHC provider unable to meet needs	1
	Refused to apply for Medicaid	1
	100% Fee	2
	Not on Medicaid	9
	Excess Assets	2
	Excess Income	1
	Functional Eligibility	4
	NMT - Functional Eligibility	1
	NMT to and from work	1
	No Action/Services Pursued	3
	Unable to Determine Financial Eligibility/Did Not Cooperate	1
	Unable to Determine Functional Eligibility/Did Not Cooperate	1
February 2024	100% Fee	2
	Excess Assets	2
	Excess Income	2
	Functional Eligibility	20
	No Action/Services Pursued	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	1
	Unable to Determine Functional Eligibility/Did Not Cooperate	3
	Service Needs all Met by HSC	1
	Specialized Equipment for Exercise Bike	1
	MW Coverage Prior to Medicaid/LOC/Assessment/Care Plan Completion	1
	AFC unable to pay room and board	1
	In Institutional Setting	2
	Outside Scope of MSPPC	1
March 2024	Functional Eligibility	13
	Excess Income	5
	Not on Medicaid	1
	No Action/Services Pursued	2

	Unable to Determine Functional Eligibility/Did Not Cooperate	2
	Excess Assets	1
	Disqualifying Transfer	1
	SPED Units Over Cap	1
	Companionship Units Over Cap	1
	100% Fee	3
	Disagree with Care Plan	1
	Health/Welfare/Safety Concerns	2
April 2023	100% Fee	1
	Not on Medicaid	6
	Excess Assets	2
	Excess Income	1
	Functional Eligibility	18
	No Action/Services Pursued	2
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
	Unable to Determine Functional Eligibility/Did Not Cooperate	1
May 2024	Supervision/Functional Eligibility	2
	Functional Eligibility	6
	100% Fee	1
	Excess Assets	2
	Excess Income	1
	Not on Medicaid	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	1
	No Action/Services Pursued	2
June 2024	Pet Care	1
	Health/Welfare/Safety Concerns	1
	NMT for Medical Transportation	1
	Functional Eligibility	13
	100% Fee	2
	Excess Income	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	1
	No Action/Services Pursued	2
July 2024	Excess Income	1
	Functional Eligibility	5
	Not in Agreement with Care Plan	1
	No action/Services Pursued	1

	Unable to Determine Financial Eligibility/Did Not Cooperate	1
August 2024	Companionship/Functional Eligibility	4
	No action/Services Pursued	1
	Chore/Lawn Care Responsibility of Homeowner	1
	Functional Eligibility	4
	100% Fee	1
	Excess Income	1
	Disqualifying Transfer	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	3
	Unable to Determine Functional Eligibility/Did Not Cooperate	2
	Outside Scope of MSPPC	1
September 2024	Functional Eligibility	16
	100% Fee	1
	Companionship/Functional Eligibility	1
	Health/Welfare/Safety Concerns	1
	Excess Income	1
	Not on Medicaid	3
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
October 2024	Functional Eligibility	16
	100% Fee	1
	Excess Assets	1
	Not on Medicaid	2
	Disagrees with Care Plan	1
	24/7 Nursing Over Monthly Cap	1
	No Action/Services Pursued	1
November 2024	Functional Eligibility	11
	Excess Income	1
	Unable to Determine Functional Eligibility/Did Not Cooperate	10
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
	No Action/Services Pursued	2
December 1, 2024 – December 13, 2024	Unable to Determine Functional Eligibility/Did Not Cooperate	1
	Excess Assets	1
	Excess Income	1

	Functional Eligibility	2
	Units Over Cap	1
	No Action/Services Pursued	1
Totals		**283**

Number of unduplicated PCPs completed for TPMs in the community.

- There were 1,125 unduplicated PCPs completed for TPMs in the community during this reporting period.

Number of unduplicated annual PCP visits to TPMs in SNF.

- There were 2,022 unduplicated annual PCP visits to TPMs in SNFs.

Number and percent of PCPs produced by transition coordinators and reviewed by the State that meet all Settlement Agreement Requirements.

- Of the 260 referrals received during this period, 212 PCPs were completed by the MFP transition coordinators and 20 PCPs were completed by the DDPM's for a total of 232 PCPs. Of these 232 PCPs, MFP has reviewed 29% and all met the SA requirements.

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS Aging Services

Policy (Section IX, Subsections A, B & C, page 14)

Implementation Strategy

New Strategy 1. Compile a list of potential services that will enhance the current service array and fill gaps in the service delivery system for potential inclusion in the 2025-2027 DHHS Executive Budget request. Services may be added to one or more of the state or Medicaid HCBS funding sources. For example, adding the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program to the HCBS waiver. CAPABLE combines the services of a handy man with the expertise of a Registered Nurse (RN) and Occupational Therapist (OT) to help adults with physical disability to continue to live in their home and receive necessary care. **(Funded services will be known by June 1, 2025)**

Progress Report:

The request to add a service that is like the CAPABLE model was not included in the Executive Budget Request to the Legislative Appropriations committee. The Executive Budget request reflects a philosophy for HHS to do what they are currently doing very well

instead of adding additional programs. The State will continue to provide the evidence based CAPBLE program with OAA funds to as many individuals as the current $150,000 budget allows. The Executive Budget Request included the following:

- $300,000 in State funds to continue to offer rental assistance to TPMs who need rental assistance to transition home from a SNF or who need assistance to remain living in the community.

- $718,522 in State funds to continue to fund APS contracted service providers so they can continue to meet the demand for this service in the most urban and frontier parts of the State.

- $5,289,397 in State and federal funds to continue to provide a transition and diversion support services to help TPMs and other Medicaid eligible individuals with a disability be diverted or transitioned out of institutional and congregate settings to integrated community living.

- $1,235,768 in State and federal funds to give a rate increase for Private Duty Nursing and Home Health services.

- $5,392,656 in State and federal funds to give targeted rate increase to ensure enough providers to meet the demand for the following services:

    - Extended person-care and nurse education

        - Proposed rate: $19.71 per 15 min unit

    - Homemaker, Chore, Personal Care - unit rate, respite, Supported Employment, Transitional Living

        - Proposed rate: $9.40 per 15 min unit

    - Non-medical Transportation - Escort, Companionship, and Supervision

        - Proposed rate: $9.10 per 15 min unit

Updated Strategy 2. During the 2023 HCBS national conference CMS informed participants that it is possible to use presumptive eligibility to assist Medicaid applicants in accessing HCBS and that six (6) states have adopted this policy. The State has requested technical assistance from CMS and will be reaching out to the fee for service states who are currently using presumptive eligibility to learn how it was implemented. Once that information is obtained, we will meet with the Medicaid Director and other internal stakeholders to discuss how we might begin the process to implement this in ND. **(Target completion date June 30, 2025)**

Progress Report:

The State held technical assistance call with CMS staff to discuss presumptive eligibility. Additionally, the State consulted with two other states that have implemented some form of presumptive eligibility for HCBS. After these discussions, the State concluded that implementing presumptive eligibility is not feasible. However, CMS recently updated its rules on presumptive care planning, which may offer a better solution to address the issue of timely access to services for TPMs. The State will consider including a policy allowing the use of presumptive care plans to help TPMs access HCBS while awaiting formal Medicaid eligibility determination in the next HCBS Medicaid waiver amendment. The State will likely submit its next waiver amendment for approval by January 1, 2026.

QSP Hub/Provider Models (Section IX, Subsection D, page 14)

Implementation Strategy

Updated Strategy 1. The State will continue to use MFP capacity building funds to maintain the work of the QSP Hub operated by the Center for Rural Health at the University of ND. The QSP Hub assists TPMs who choose their own individual QSPs to successfully recruit, manage, supervise, and retain QSPs. The QSP Hub will also help TPMs to understand the full scope of available services and the varying requirements for enrollment, service authorization, and interaction with HCBS case management.

The State worked with the QSP Hub to develop a performance measure to evaluate the success of the support provided by the QSP Hub to TPMs who request assistance with self-direction. The State will track the number of agencies and individual QSPs that were given technical assistance by the Hub and the number who were successfully enrolled as a provider.

Challenges to Implementation

The State worked with the QSP Hub to develop the following performance measure to evaluate the success of the support provided by the QSP Hub to TPMs who request assistance with self-direction

Progress Report:

Of the 43 Agencies that were enrolled as a QSP as of December 31, 2024, 56% or (24) of the agencies received technical assistance from the QSP Hub. Of the 372 individuals enrolled during this same period 35% (133) of the new providers received technical assistance from the QSP Hub. These numbers may not reflect the true number of QSP who get support, as any individual or agency that received help from the QSP Hub, that was not approved in the same calendar month that they received help, was not recorded in these numbers. The QSP Hub also fields hundreds of calls from QSPs which has reduced the number of provider calls that used to be fielded by the HCBS Case Managers and QSP Enrollment. Providers are mostly looking for reassurance that their application

was submitted correctly or have general questions about the process. One area that has been difficult for some providers is understanding how to upload documents in the enrollment portal. In response to this issue, the QSP Hub created instructional videos that will walk QSPs through the process. **(Ongoing strategy funded through September 2025)**

See Section IX. Performance Measures

Updated Strategy 2. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will implement any changes to the provider model or include formal self-direction policies in the HCBS waiver and Medicaid State Plan – Personal care that may be approved during the 2025-2027 legislative session.

Challenges to Implementation

Formal self-directed service options are part of most Medicaid funded HCBS. States can collect federal medical assistance percentage (FMAP) for self-directed services if approved by CMS. However, because most of the in-home services provided to eligible individuals in ND are funded under the State's Service Payments to the Elderly and Disabled (SPED) program additional state general fund appropriations would be required to pay for the fiscal intermediary services required under formal self-direction.

Remediation

The State will take all factors into consideration when determining what if any new provider models are needed to ensure TPMs can live in the most integrated setting appropriate to their needs. The State will determine the feasibility of a variety of provider models including the co-employer/agency with choice model and a QSP rural cooperative.

The State has also made considerable investment in systems to improve the QSP enrollment experience and will provide a system where QSPs can market their services to the public. The State also offers free access to EVV and a documentation and billing submission system that will shift some of the administrative burden off of the providers. The State will continue to weigh the options and if another model is identified Aging Services will request that model/self-direction be part 2025-2027 DHHS Executive Budget request. **(Updated Target completion date for decision December 1, 2025)**

Right to Appeal (Section IX, Subsection E, page 14)

Updated Implementation Strategy

TPMs cannot be categorically or informally denied services. Policy requires HCBS case managers to make formal requests for services or reasonable modification requests when there are unmet service needs necessary to support a TPM in the most integrated setting

appropriate. All such requests and appeals must be documented in the PCP. TPM and HCBS applicants are made aware of the right to appeal any decision to deny/terminate/reduce services by maintaining information in the Application for Services form, and the “HCBS Rights and Responsibilities” brochure. **(Ongoing strategy)**

Progress Report:

See Section IX. Performance Measures

Policy Reasonable Modification (Section IX, Subsection F, page 14)

Implementation Strategy

Updated Strategy 1. HCBS policy includes the process to request a reasonable modification for review and consideration. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will continue to meet with the Board of Nursing to review all medically related reasonable accommodations to review trends and make recommendations for policy or legislative changes that will allow more TPMs to live at home and receive necessary healthcare. **(Ongoing strategy)**

Progress Report:

The Program Administrators, Director of Aging, and Legal Services meet with the ND Board of Nursing every six (6) months to review accommodations. Last meeting was November 25, 2024.

Strategy 2. The State will track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity. Reports are reviewed at a quarterly meeting attended by all DHHS Divisions that administer HCBS. Strategies to address identified issues will be established and included in future revisions of the IP**. (Ongoing strategy)**

The most common modification requests in 2024 include requests to:

1. Modify extended personal care services to allow individuals to receive a ride and escort to medical appointments because of communication or other impairments.

   Because of the number of requests received to modify this service, the State submitted a waiver amendment to CMS to make this an allowable task. Because it was approved case managers will no longer need to request a modification of policy for this purpose because it is now a permanent part of the service. **(Amendment approved January 1, 2025 and ongoing)**

2. Allow a Registered Nurse to teach an individual QSP how to administer insulin, narcotics, and complete wound care tasks for specific clients.

The accommodations requested to modify the nurse practice act need to be approved based on the medical needs of each individual so a request to make any of these tasks a permanent part of the rules will not be requested at this time.

Progress Report:

See Section IX. Performance Measures

Denial Decisions (Section IX, Subsection G, page 15)

Strategy 1. and 2. listed in Section IX.E and the associated measure also apply to this section.

Service enhancements (Section IX, Subsection H, page 15)

Updated Implementation Strategy

Strategy 1. Continue to recruit and retain residential habilitation and community-support services funded under the HCBS 1915(c) Medicaid waiver to provide up to 24-hour support, and community integration opportunities for TPMs who require these types of supports to live in the most integrated setting by assisting up to five (5) additional eligible agency QSPs with paying for their CQL accreditation. **(The State has funding available through June 30, 2025 or until funds are expended)**

Progress Report:

The State enrolled seven (7) new agency QSPs to provide these services in 2024. The State provided funds to pay for CQL accreditation to 15 agency QSPs. Eleven of the agencies were already enrolled and four (4) new agencies have enrolled. Paying for CQL accreditation has been an effective strategy for recruiting QSP agencies. There are currently 27 community support, and 27 residential habilitation providers enrolled. As of December 31, 2024, 64 TPMs are receiving 24-hour supports using these services.

See Section IX. Performance Measures

Updated Strategy 2. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS using funds from the 9817 10% HCBS fund. The State will use existing procurement rules to create an alternate rate augmentation payment that will be used to implement rate enhancements to encourage QSPs to serve additional TPMs. QSPs who agree to accept TPMs who need a lot of care, or QSPs who agree to provide care to individuals who only need access to intermittent care, would be paid a lump sum amount to augment the rate already paid for these services thus increasing access to HCBS for TPMs. **(Ongoing through October 31, 2025)**

Progress Report:

The State implemented the rate augmentation project. The following requests were approved in DOJ Year 4.

HCBS Territory	Date of Request	Category of Request
1	5/22/2024	Supplies for Chore
1	5/28/2024	Supplies for Chore
1	10/11/2024	Additional Staff Time
2	3/15/2024	Emergency Respite
3	3/15/2024	Emergency Respite
4	7/30/2024	Supplies for Chore
4	10/28/2024	Supplies
5	7/2/2024	Additional Staff
5	8/16/2024	Additional Staff
5	9/19/2024	Additional Staff
7	6/3/2024	Nutritional Supplements
7	6/3/2024	Nutritional Supplements
7	8/27/2024	Supplies, Hotel
7	10/1/2024	Additional Staff
7	12/4/2024	Additional Staff
7	12/11/2024	Assist of two

Updated Strategy 3. Implement the following services and enhancements to the HCBS delivery system that were included in the 2023-2025 DHHS budget.

Progress Report:

- Increase the quality of HCBS by reimbursing QSP Agency on-call staff.
    - To enhance the quality of HCBS, the State will reimburse QSP agencies enrolled to provide personal care to maintain on-call staff. The State was authorized $351,000 for this purpose in the current biennial budget. However, with 168 agencies enrolled to provide personal care, there are not enough funds to cover on-call staff for every agency. To address this, the State will establish a competitive grant process. This will allow agencies currently serving HCBS recipients to apply for funds, either to provide stipends for on-call staff or to hire “floater” positions. The floaters will be available on demand to address urgent needs, such as when a scheduled staff member is unable to complete their shift or in other unexpected situations**.** **(Target completion date March 1, 2025 and on-going)**

- Pay for two (2) home delivered meals per day under the HCBS Medicaid waiver, SPED and Ex-SPED.

- Add companionship services to SPED and Ex-SPED.

- Allow bed hold days for community support and residential habilitation paid through the HCBS Medicaid waiver.

- Increase individual adult foster care maximum rate from $96.18 per day to $150.00 per day and to increase the family home care rate from $48.12 per day to $72.50 per day.

- Create a personal care with supervision service in the HCBS Medicaid waiver and switch Medicaid state plan personal care recipients who have supervision needs to the HCBS waiver.

    - All five (5) projects listed above have been completed as of December 13, 2024.

Updated Strategy 4. Finalize the recommendations that will be made by the individual adult foster care workgroup to the current adult foster care rules and policy. The goal of the committee is to review all rules and policy governing this service and to find ways to improve the experience for TPMs and providers.

The workgroup is made up of State staff responsible for writing policy and licensing the individual adult foster care homes. The recommendations made by the internal committee were shared at a meeting on December 5, 2023. The State will invite TPMs, family members, guardians, State administrative staff, tribal representatives, HCBS case managers, QSPs, and other interested stakeholders to participate.

State staff will be responsible for taking any regulatory action necessary to implement the agreed upon recommendations from the workgroup. **(Workgroup established December 2022. Recommendations developed and reported December 31, 2023)**

Progress Report:

A stakeholder meeting was held on December 5, 2023, with 27 attendees. There was no verbal or written feedback provided during meeting. Areas represented were Adult Foster Care Provider, Government Agency, Interested Providers, Other-unspecified. An anonymous survey poll was sent out prior to the stakeholder meeting and was again presented at the start and end of the meeting, completed by seven (7) attendees.

Current Adult Foster Care providers responded that they are not utilizing their approved respite hours. One (1) responded that they "sometimes" feel they have adequate time away from providing care. Respondents did not have suggestions for the workgroup regarding ideas to recruit new providers or what would make being an Adult Foster Care provider more attractive for applicants.

A follow-up internal workgroup meeting was held December 20, 2023 to discuss the

survey results and changes moving forward to NDAC or Adult Foster Care Policy. No changes were implemented following this discussion due to lack of provider feedback. On December 13, 2024, State staff met with two (2) ND Legislative Representatives to discuss suggested changes. Discussions regarding a legislative bill in the 2025 Legislative Session or completing an internal change to NDAC 75-03-21 through Administrative Code amendments. At the end of the meeting, a decision was made by the Legislative Representatives and Aging Services staff reopen the workgroup and work towards amending the NDAC. Workgroup will reconvene following 2025 Legislative session to work on amendments to NDAC 75-03-21. This workgroup will contain additional members including invites to the Legislative Representatives. Workgroup has been scheduled for May 20, 2025.

House Bill 1460 was introduced in the 25-27 Legislative session to increase respite hours for individual adult foster care providers. The State will continue to follow the bill and will comply with the request if the bill passes both chambers and is signed by the Governor.

Section IX. Performance Measure(s)

Number of QSPs offering on-call services.

- See progress report in Subsection IX 3.

Number of TPMs who self-direct or who express interest in self-direction who are supported by the QSP Hub.

- The QSP Hub supported 34 individuals that identified as self-directing. The topics these TPMs called seeking support with included:
    - Claim status of for their QSP. In this case the QSP was a family member and were needing the payment for the provider.
    - Seeking support and needing a QSP. In these cases, TPM's were connected with the ADRL.

Number of outreach efforts to increase awareness of the role of the QSP Hub.

- The QSP Hub participated in 35 different outreach events during this reporting period. These events targeted a variety of groups and populations including but not limited to: Job Service hiring events, expositions at community engagement events, conferences, college events, and high school events with students. The QSP Hub does not currently track any outcomes from these outreach events but will envelope a process to track it in the future.

Number of TPMs receiving extended personal care.

- A total of 127 TPMs received extended personal care.

Number of QSPs successfully enrolled to provide residential habilitation and community support services.

- There are currently 27 QSPs enrolled to provide these services.

Number of appeals filed after a denial of a reasonable modification request.

- One (1) appeal was filed after a denial of a reasonable modification request. The result of this was that the OAH appeal was denied by Legal and guidance received if individual wished to appeal, must go through the civil rights appeal process.

Number of requests for reasonable modifications received and outcome of those requests per reporting period.

Reasonable Modifications			
Month/Year Request	**Accommodation Type**	**Approved**	**Denied**
December 14, 2023 – December 31, 2023	Nursing Tasks	1	
	Med Management	1	
January 2024	Nursing Tasks	4	
	Services over the cap	1	
February 2024	Nursing Tasks	3	
	Services over the cap	1	
	Additional Hours	1	
March 2024	Nursing Tasks	7	
	Medical Transportation/escort	1	
	Service over cap - Companionship		1
April 2024	Nursing Tasks	10	
May 2024	Nursing Tasks	3	
June 2024	Nursing Tasks	8	
July 2024	Nursing Tasks	5	
August 2024	Nursing Tasks	6	
September 2024	Nursing Tasks	6	
October 2024	Nursing Tasks	8	
November 2024	Nursing Tasks	19	
December 1, 2024 – December 13, 2024	Nursing Tasks	6	
Totals		**91**	**1**

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHHS Aging Services & Medical Services

LTSS Options Counseling Referral Process (Section X, Subsection A, page 15)

Implementation Strategy

The current LTSS Options Counseling referral process requires staff to complete the SFN 892 – Informed Choice Referral for Long-Term Care form during each visit. The form requires a signature from the TPM or their legal decision maker to confirm they received and understand the required information. Educational materials to help TPMs understand their options have been developed and are required to be used during each visit. **(Ongoing strategy)**

Progress Report:

See Section X. Performance Measures

NF LoC Screening and Eligibility (Section X, Subsection B, page 15)

Implementation Strategy

Strategy 1. Members who meet criteria for a particular SNF service must be offered that same service in the community if the community-based version exists or can be provided through reasonable modification to existing programs and services. As part of LTSS Options Counseling implementation, all HCBS case managers were given access to the TPM's NF LoC screening evaluations to help determine which supports are necessary for them to live in the most integrated setting appropriate. If necessary, services are identified but are not available in the community, policy requires the HCBS case manager to formally request services or submit a reasonable modification request to the State for consideration. This information can currently be incorporated into the PCP. **(Ongoing strategy)**

Challenges to Implementation

HCBS case managers may not know if a community-based version of a SNF service exists. Requests for necessary services may involve supports provided through external providers or various Divisions within DHHS including Aging Services, Medical Services, Developmental Disabilities, Behavioral Health, Vocational Rehabilitation, or the Human Service Centers.

Remediation

The State will continue to hold a bi-weekly interdisciplinary team meeting to staff necessary but unavailable service requests with staff from Aging Services, Behavioral Health, and the Human Service Centers to assist individuals who have a serious mental illness and need behavioral health supports to succeed in a community setting. The purpose of the meetings is to discuss how the Divisions can work together to provide the necessary services that will allow the TPM to live in the most integrated setting appropriate.

This meeting can also include other DHHS divisions who may be involved in the TPMs care. Division staff discuss reasonable modification requests or staff situations where it is unclear which HCBS waiver or State plan benefit would best meet the needs and wishes of the TPM. **(Ongoing strategy)**

Progress Report:

See Section X. Performance Measures

Strategy 2. Continue to conduct an annual NF LoC screening for all Medicaid recipients living in a SNF. The NF LoC determination vendor provides written reminders to the TPMs or their legal decision maker and the SNF that the annual level of care is due. **(Ongoing strategy)**

Challenges to Implementation

If a TPM residing in a SNF fails to screen at a NF LoC during the annual redetermination, Federal Medicaid rules require them to be discharged within 30 days. This could negatively impact TPMs who need sufficient time to transition back to the community.

Remediation

If an individual will no longer meet NF LoC criteria, the SNF can request that the State put an administrative hold on the current NF LoC screening for up to 120 days. This will give the SNF and transition team time to create a safe discharge plan for a return to community living. **(Ongoing strategy)**

Progress Report:

SNFs do annual screenings for TPMs. The NF LoC vendor sends reminders that the annual level of care is due. The TPM or legal decision maker is provided a copy of the annual LoC screening upon determination. TPMs are made aware that they must continue to meet NF LoC to remain eligible for Medicaid paid SNF care.

Strategy 3. Conduct annual in-person regional meetings with SNFs and offer other webinars to train SNF staff on the USDOJ SA, annual NF LoC requirements, HCBS options and effective discharge planning to ensure TPMs can live in the most integrated setting. **(Completed December 31, 2024)**

Progress Report:

116 professionals from SNF and hospitals across the State were reached in eight (8) in person trainings and one virtual meeting. In-person trainings were held in the following cities:

Bismarck, Minot, Williston, Dickinson, Jamestown, Devils Lake, Grand Forks and Fargo.

New Strategy 4. Aging Services staff are working with the Behavioral Health Division and the State Hospital to streamline transitions and improve working relationships and expectations of the role that the behavioral health community has in ensuring the health and welfare of transitions involving TPMs with co-occurring mental illness and substance use disorders. Representatives from both the Human Service Centers and the State Hospital are participating in person-centered planning team meetings and will develop a set of goals and expectations of how each entity can support TPMs post transition. **(Recommendations complete February 1, 2024)**

Progress Report:

The overarching goals and vision are to create a systematic approach to work with individuals with co-occurring physical and behavioral health needs.

The group identified the following types of training that would help a QSPs support individuals with behavioral health issues.

- Motivational behavior changes and de-escalation training
- Interventions to use when encountering TPMs who are actively using drugs.
- General mental health awareness and personal resiliency.

The State is working through the procurement process to contract with an identified vendor who will provide this training. The State's goal is to have this training completed by August 1, 2025. The group is also recommending there be ongoing consultation and crisis intervention support for providers working with someone who is in crisis because of a behavioral health or substance use issue. The IP contains additional strategies to implement these goals during Year 5. **(Ongoing Strategy to collaborate with behavioral health community)**

New Strategy 5. The State will work with behavioral health and traumatic brain injury (TBI) subject matter experts to create a process for QSPs to earn a behavioral health and/or TBI endorsement as part of QSP enrollment. The endorsement would be earned after agency QSP staff or an individual QSPs completes specialized training that will provide them with additional skills to help support TPMs with specialized needs. The State will work to identify the type of training and skills necessary to earn the endorsement. Training could include de-escalation, therapeutic response, and motivational interviewing. The State will also consider the feasibility of paying a higher rate to QSPs that have this endorsement when working with TPMs who need this level of specialized training to ensure successful community living after the next biennium.

Progress Report:

The State working with the behavioral health subject matter experts has identified the type of certification the community support and residential habilitation agency QSPs to need to earn to receive a behavioral health endorsement as part of QSP enrollment. The endorsement would be earned after agency leadership i.e. owners, registered nurses, field staff supervisors complete specialized training that will provide them with additional skills to help support TPMs with behavioral health needs. The State, with the help of the State Hospital has identified the type of training that will be provided. Training will include de-escalation, positive behavioral support, trauma and trauma informed care, crisis support, and personal protection skills. The State will offer grant opportunities to pay the costs of sending residential habilitation and community supports agency staff to attend the training. This educational opportunity is based on a train the trainer model, so the leaders of these organizations have the capacity to train their field staff. In the future, the State will also consider the feasibility of paying a higher rate to QSPs that have this endorsement when working with TPMs who need this level of specialized training to ensure successful community living.

The State is still working on the development of a behavior health credential and other training opportunities that could be offered to other types of individual and agency QSPs. **(Updated target completion date ~~July 1, 2024~~ December 14, 2025)**

New Strategy 6. Continue to educate QSPs about the existence and availability of crisis services that can assist when a TPM being supported in the community has a mental health crisis. The services include the mobile crisis team and crisis facilities.

The mobile crisis team is coordinated through the State's Human Service Centers (public behavioral health clinics). The mobile crisis team can meet a person where they are, whether this is their home, work, school, or other location. These services are provided by Human Service Center staff or contracted providers in Bismarck, Fargo, Jamestown, Grand Forks, Williston, Minot, and Dickinson. Services will be available in Devils Lake once a provider is found.

What the mobile crisis team offers:

- Stabilizes the crisis quickly.
- Assess for risk of harm to self/others.
- Helps problem-solve by connecting the person to services and resources.
- Provides after-crisis support.

Crisis facilities also offer walk in support at a crisis facility 24 hours 7 days a week for a brief screening in the Bismarck, Fargo, and Jamestown regions. Individuals can walk in and receive short-term, recovery-focused services to help resolve a behavioral health crisis. This could also include one or more overnight stays. Services include withdrawal management, supportive therapy, and referrals to needed services.

Individuals can also walk into any human service center between 8:00 a.m. and 5:00 p.m. CST for a behavioral health screening. Mental health professionals work one-on-one with people to assess their situation and help them connect to services either at a human service center or community provider to prevent a future crisis.

If a TPM cannot physically get to a Human Service Center or contracted provider for a behavioral health screening the case manager may request that a reasonable modification to the "walk-in" policy be made. The mental health professionals may make a home visit or other modifications to ensure they have access to necessary care. **(Ongoing Strategy)**

Progress Report:

The State will continue to work with the mobile crisis teams and educate case managers and QSP about how they can access these resources in their community. The State recently advertised the availability of 988 services in the QSP newsletter. 988 is another tool that can be used for mental health crisis including suicide prevention. The State does not have a current process to track when crisis services are used to help a HCBS recipient in the field. The Human Service center keeps their own records, but they are not shared with Adult and Aging Services Section staff.

SME Diversion Plan (Section X, Subsection C, page 16)

Implementation Strategy

During the first year of the SA the SME drafted a Diversion Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving diversions, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

Progress Report:

The State has implemented many of the strategies recommended in the SME Diversion Plan. However, the plan has been removed from the Year 5 IP, and progress is no longer tracked in this format. Instead, the most up-to-date SME recommendations are available in the SME Compliance Report online.

Link to October 2024 SME Compliance Report

Section X. Performance Measure(s)

Number of individuals reached through group SNF in-reach presentations.

- There were 75 annual SNF presentations completed in 2024 with 895 individuals in attendance.

Number and percent of unduplicated LTSS OC visits made to TPMs residing in home, hospital and SNFs.

- There were 1,151 unduplicated visits made during this reporting period.
  - SNF – 856 (74%)
  - Hospital – 227 (20%)

- Home/Community – 10 (1%)
- Swing bed – 58 (5%)

Number of unduplicated annual PCP visits to TPMs in SNF.

- There were 2,022 unduplicated annual PCP visits to TPMs in SNFs during this reporting period.

Number of cases staffed per interdisciplinary team meetings and outcomes.

- There were 93 interdisciplinary staffing of 74 individual's cases during this DOJ year. Note that some individuals have been staffed more than one time,
  - December 14, 2023 – December 31, 2023 – 3
  - January 2024 – 2
  - February 2024 – 7
  - March 2024 – 12
  - April 2024 – 3
  - May 2024 – 18
  - June 2024 – 9
  - July 2024 – 3
  - August 2024 – 8
  - September 2024 – 5
  - October 2024 – 14
  - November 2024 – 6
  - December 1, 2024 – December 13 2024 – 3
- The outcomes of staffings include:
  - Providing case managers direction on how to effectively mitigate risks and develop a thorough risk assessment.
  - Guidance on how to interact with individuals who struggle with behavioral health symptoms.

- Collaboration between the staff within behavioral health, developmental disabilities, vulnerable adult protective services, MFP/ADRL transitions, and other community agencies to provide comprehensive services.

- Providing overall technical assistance and education as to how services may be authorized to fit the needs of consumers.

SA Section XI. Transition Services

Responsible Division(s)

DHHS Aging Services

MFP and Transitions (Section XI, Subsection A, page 16)

Implementation Strategy

Updated Strategy 1. The State will continue to use MFP Rebalancing Demonstration grant resources and transition support services under the HCBS Medicaid waiver to assist TPMs who reside in a SNF or hospital to transition to the most integrated setting appropriate, as set forth in the TPM's PCP.

Medicaid transition services may include short-term set-up expenses and transition coordination. Transition coordination assists a TPM to procure one-time moving costs or arrange for all non-Medicaid services necessary to move back to the community, or both. The non-Medicaid services may include assisting with finding housing, coordinating deposits, utility set-up, helping to set up households, coordinating transportation options for the move, and assisting with community orientation to locate and learn how to access community resources. TPMs also have access to nurse assessments and back-up nursing services.

TPMs transitioning from an institutional setting will be assigned a transition team. The transition team includes an MFP transition coordinator, HCBS case manager, and a housing facilitator if the PCP indicates housing is a barrier to community living. The Transition Team will jointly respond to each referral with the MFP transition coordinator being responsible to take the lead role in coordinating the transition planning process. The HCBS case manager has responsibility to coordinate the Medicaid services necessary to implement the PCP and facilitate a safe and timely transition to community living. **(Ongoing strategy)**

Progress Report:

To ensure these services are available and administered consistently statewide the State will:

- Continue to evaluate the current capacity of the MFP transition coordinators in Bismarck, Grand Forks, Minot, and Fargo to determine if additional FTEs

are needed. If the State determines there is a need, the State will request funds in future MFP budgets which requires approval from CMS. The State has begun to do more contract monitoring to assess where additional guidance is needed in each region. **(Ongoing strategy)**

    - There were no new MFP transition coordinator or transition assistant positions during Year 4 of the SA but three (3) additional housing facilitators.

- Add a requirement to the next CIL transition coordination contracts that would require the CILs to attempt to hire additional staff to meet the demand for transition coordination in their service territory.

    - The CIL contracts were updated to add this language.

- Provide technical assistance, training, and contract monitoring of the CIL transition coordination contracts to continue to address the need for the MFP transition coordinators to provide high quality transition support statewide and consistently adhere to required policy and procedures. Guidance will be tailored to meet the needs of each CIL region. If problems are found CILs will be required to submit a corrective action plan that is approved by the State to mitigate the issues.

    - The State completes on-going contract monitoring. In addition, one of the MFP team members is providing on-site technical assistance to the CILs.

Updated strategy 2. Continue to enhance MFP supplemental services. These services are one-time to short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. The State gathered input from stakeholders and transition coordinators to design and implement additional supplemental services to assist TPMs in transitioning to the community. **(Ongoing Strategy)**

Newly implemented MFP supplemental services include:

- Increasing the amount and access to food pantry stocking for a 30-day period.

- Home modifications and vehicle adaptations available prior to transition so TPMs have what they need to successfully transition day one.

- Targeted training for direct service workforce on the unique needs of the individual prior to transition. These costs are part of the administration budget.

The State is seeking additional funds to further enhance the following supplemental services.

- Assistive technology, companion animals, and other devices to increase

opportunities for social interaction.

- Home repairs and deep cleaning.
- Onetime health supplies for example, incontinence supplies, diabetic supplies etc.

Progress Report:

Additional funds were received and Supplemental Services are being widely used across the state for MFP recipients. Supplemental Services have been in operation for over a year.

MFP Policy and Timeliness (Section XI, Subsection B, page 16)

Updated strategy 1. The State will continue to require that transitions that have been pending for more than 90 days are reported to the MFP program administrator. The MFP State staff will facilitate a team meeting to staff the situation with the transition coordinator, HCBS case manager and housing facilitator and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. Transitions that have been pending for more than 100 days are also reported to the SME. The Agreement Coordinator will be responsible for securely forwarding a list of the names of TPMs whose transition has been pending more than 100 days. The report will include a description of the circumstance surrounding the length of the transition. The State currently tracks the days from signed consent to transition. **(Ongoing strategy)**

Progress Report:

This report was submitted to the SME and US DOJ upon request during this reporting period. Feedback is responded to in writing and verbally during meetings with the SME team.

Challenges to Implementation:

The SA requires that transitions take no more than 120 days. Although the State agrees that is an appropriate goal for most transitions, some transitions take longer than the 120 days because of the complex needs of the TPM. Rushing transitions can result in unsafe discharge. In some cases, considerable barriers to transition need to be met before a plan is made to move back to the community. For example, TPMs may have an upcoming surgery, or need to learn to use prosthetics before they are ready to transition. If transitions are going to be successful it is necessary to take the time to develop a solid transition plan. The State will continue to work with the SME to further address this issue.

Progress Report:

Of the 139 completed transitions in Year 4, seventy-three percent (73%) of TPMs

were transition in 120 days or less. Twenty-seven (27%) percent took longer than that.

TPMs who transitioned using the Transition and Diversion Services Pilot Project (TDPP) were all transitioned home in 30 or less days. This pilot program does not require a TPM to have resided in the nursing home for 60 or more days. This is a requirement of MFP. The State believes that this can be attributed to a shorter length of stay helping to make transitions happen quickly. If people have recently entered the nursing home and indicate a desire to move to the community, steps can be taken to help them keep their housing, and secure their income, facilitating a smoother transition. Funds to continue providing the TDPP were included in the 25-27 Executive Budget request, and it was fully funded in the Department's budget appropriation bill (HB 1012) that was recently passed by the House and will be heard soon in the Senate.

Updated Strategy 2. The State will continue to conduct a quarterly review of all transitions to identify effective strategies that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to successfully support TPMs in the community. During the past year the State has identified the following issues to be consistent barriers to TPMs accessing community living. There are strategies in other relevant sections of the IP to mitigate these barriers.

- Lack of providers in certain areas of the State,
- Not enough accessible housing units,
- Timeliness of social security redetermination regarding a change in residence i.e., move from nursing home to home,
- Behavioral health and substance abuse that may jeopardize community living,
- Behaviors towards providers jeopardizing services,
- Criminal conviction history and,
- Individuals who lack capacity but do not have a legal decisionmaker.

Review meetings are conducted quarterly. The State continues to develop the training and strategies to correspond with the needs of State staff, HCBS case managers, MFP transition coordinators and housing facilitators.

Progress Report:

The State will continue to conduct a quarterly review of all transitions to identify effective strategies that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to successfully support TPMs in the community. In 2024, 95 TPMs had a quarterly review because they were waiting for transitions for 90 or more days. The State identified the following issues to be the top ten (10) barriers to TPMs

accessing community living. TPMs may have barriers in multiple areas. An update to the settlement agreement requires the State to design and implement two (2) new strategies to mitigate barriers TPMs face when trying to transition to the community in the Year 5 IP.

2024 Top 10 Barriers to Transition	N=95
TPMs on 90+ day report	
Accessible unit needed	51
Needs Housing Voucher	44
Needs a provider	35
Needs a 24/7 provider	31
Needs special equipment/durable medical equipment	28
Behavioral Health	21
Capacity Issues	19
Credit Issues	17
Unstable Health Concerns	15
Lack of Documents	15

New Strategy 3. Social Security and Medicaid can be slow to change the living arrangements of TPMs who have a short-term stay in a SNF because they may not know that an individual is being discharged and they may also be in jeopardy of losing their housing because landlords are not aware that they intend to return home. Sometimes utility and other bills go unpaid while a TPM is in the nursing home. All these things can complicate and delay transition for TPMs who are eager to return to community living. The State will create educational materials for the LTSS OC and SNF discharge planners to help educate themselves, landlords and TPMs in the SNFs about the steps that need to be taken to ensure TPMs can keep their housing, pay their bills, and receive the correct social security benefits post discharge. **(Completed April 1, 2024)**

Progress Report:

Educational tools have been created for distribution to landlords, SNFs and TPMs. Aging Services is collaborating with Medicaid to provide information to all individuals upon screening to further the educational reach of the information.

New Strategy 4. Aging Services staff will request to work with the Guardianship Association of ND to assist in determining the best approach for helping TPMs who lack capacity but do not have a legal decision maker to help them make important decisions, including decisions that impact their ability to live in the community and access necessary care. The goal of the collaboration would be to develop strategies and recommendations to help ensure TPMs in this situation are afforded the right to live in the most integrated setting appropriate to meet their needs. **(Target completion date ~~July 1, 2024~~ December 13, 2025)**

Progress Report:

The State will begin working on this issue during Year 5 of the IP. There are several bills

that have been introduced in the current Legislative session to try and make improvements in the law that governs guardianship and to create a Guardianship Section that would be housed in the ND Supreme Court. Staff from Adult and Aging Services Section are tracking the bills.

New Strategy 5. The State will work with Legal Services of ND to develop "futures planning" events and tool kits to educate people about the need to take steps now to ensure their health care and other wishes are known in the event they become incapacitated. The goal of the events will be to provide education and have a completed durable power of attorney for health care or other legal document that is ready to be shared with their family and healthcare providers by the end of each event. **(Updated target completion date ~~December 13, 2024~~ April 1, 2025)**

Progress Report:

The State contracted with Legal Services of ND to hold scheduled "futures planning" events and to distribute tool kits to educate HCBS recipients about the need to take steps now to ensure their health care and other wishes are known in the event they become incapacitated. The workshops are targeted toward Medicaid members, but anyone interested can attend a workshop or the virtual events. The goal of the in-person events will be to provide education and have a completed durable power of attorney for health care or other legal document that is ready to be shared with their family and healthcare providers by the end of each event. Legal Services will also be holding monthly educational webinars from November 2024 – March 2025. HCBS recipients who want to create advance directives can also schedule a virtual appointment with attorneys from Legal Services. The State will track the number of HCBS recipients who attend the events and complete advanced directives to include in future reports.

New strategy 6. Some TPMs, especially those who have been residing in a SNF for a long time, may lack the community living skills necessary to create and follow a household budget that will ensure they are able to manage their expenses post discharge. The State will consider the possibility of requesting to add fiscal management services to eligible TPMs under one or more of the federally funded HCBS. The service would allow the TPM to work with a subject matter expert to complete a monthly budget and develop financial goals that will support long-term success with community-living. **(Target completion date June 1, 2024)**

Progress Report:

The State did not implement this strategy as originally planned. MFP identified back rent owed as a barrier to transition but the extent of the problem did not warrant a request to add fiscal management services to the current service array. To address this issue, MFP Supplemental Services are used to pay the back rent and, when appropriate, require the TPM to complete the recommended modules in the "*Smart with My Money"* online course.

Transition Team (Section XI, Subsection C & D, page 16-17)

Implementation Strategy

To ensure TPMs have the supports necessary to safely return to an integrated setting, the HCBS case manager, MFP transition coordinator and housing facilitator (if applicable) will work as a team to develop a PCP that addresses the needs of the TPM.

Once a TPM is identified through the LTSS Options Counseling referral process or other in-reach strategy, the MFP transition coordinator will meet with the TPM to explain MFP and the transition planning process. Within five (5) business days of the original referral an HCBS case manager is assigned and the team must meet within 14 business days to begin to develop a PCP. The MFP transition coordinator is responsible for continuing to provide transition supports and identify the discharge date. Once the TPM is successfully discharged, the MFP transition coordinator continues to follow the TPM for one year post discharge. The HCBS case manager also provides ongoing case management assistance. **(Ongoing strategy)**

Progress Report:

If the discharge date is within two (2) weeks or less, the entire transition team is notified so everyone is aware that they need to act and finalize their assignments before the transition date.

Transition Goals (Section XI, Subsection E, page 17)

Implementation Strategy

Updated Strategy 1. By December 14, 2024, through increased awareness, including in-reach and outreach efforts, person-centered planning and ongoing monitoring and assistance, the State will use local, State, and Federally funded HCBS and supports to assist at least 60% of the TPMs who request transition to the most integrated setting appropriate. Referrals are the number of TPMs who have signed consent to participate in MFP or ADRL transitions and are actively waiting to transition. The State will also divert at least 150 TPMs from SNF to community-based services. **(Ongoing Strategy)**

Challenges to Implementation

The most significant challenge is recruiting and retaining providers who can employ enough direct care staff to provide 24-hour supports when that level of care is necessary to support the TPM in the community.

Remediation

The primary remediation effort is to address the workforce issue through the MFP capacity building funding and the ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds. These funds will be used to offer additional incentive grants to recruit new QSPs, fund the QSP Hub and the QSP portal, improve retention and

training of providers, and improve the ability of TPMs to find QSPs that match their service needs through the Connect to Care system formally referred to as ConnecttoCareJobs platform. This system connects individuals to a platform for providers to market their skills making it more likely to attract potential clients.

Progress Report:

See Section XI. Performance Measures.

Updated Strategy 2. The QSP Hub recently conducted a second (2023) QSP survey with Agency and individuals QSPs. The survey received a good response rate. Thirty-four percent (34%) of agencies and 22% of individual QSPs responded to the survey. **(Completed December 31, 2023)**

Progress Report:

The 2024 survey was conducted in August 2024. Thirty-seven percent (37%) of agencies and 28% of individual QSPs responded to this survey. This is an increase in providers who responded from last year. The QSP survey report was drafted by the QSP Hub and is available online. Link to QSP Survey Report

Updated Strategy 3. The QSP Hub plans to complete a provider survey annually. The State will work with the QSP Hub and the lead UND researcher, to develop a QSP capacity survey. The survey will try to determine the ability of current providers to staff their currently authorized hours, ability to staff increased hours, and capacity to serve additional clients. The State will continue to use the information from the study to develop recruitment and retention strategies that appeal to what QSPs said they like about providing direct care i.e., ability to help others and job flexibility. **(Completed December 13, 2024**)

Strategy 4. The State tracks TPMs in the case management system using a unique identifier and will report unduplicated transition and diversion data. **(Ongoing strategy)**

Progress Report:

See Section XI. Performance Measures

Section XI. Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

- Four (4) QSP grants were awarded, each for $50,000.
    - Two contracts were extended, and the providers are in the process of completing their scope of work.
    - Two contracts were terminated due to the providers inability to meet the terms of the contract.

Number of TPMs who were re-institutionalized for 30 days or more and the primary reason.

- There were 19 TPMs (21 re-institutionalization events) who were re-institutionalized for 30 days or more during this time period.
    - 5 – Acute Care Hospitalization followed by long-term rehabilitation
    - 14 – Deterioration in health
    - 1 – Deterioration in mental health
    - 1 – Lack of sufficient community services

  Two (2) of the individuals had multiple re-institutionalization events that each exceeded 30 days. One (1) of those individuals died during re-institutionalization.

  Of the 139 TPMs that transitioned during this report period, 14% were re-institutionalized.

Transition 60% of those requesting transition, who have consented, and are eligible.

- Of the 217 individuals who requested to transition, 139 were transitioned which is 64% of all those requested to transition.

SA Section XII. Housing Services

Responsible Division(s)

DHHS

The State's experience implementing the settlement agreement has reinforced an understanding of how important it is to help ensure that a person has access to a place to live that they can afford and that is able to meet their needs. As such, one of the primary areas of focus in Year 4 of the Implementation Plan will continue to be a structured effort to begin to match some of the hardest-to-resolve housing barriers to a broadly defined set of solutions that can help alleviate the barrier(s). We will draw on information gathered during the first four (4) years of the IP to inform next efforts, including, as an example, information gathered from housing transition specialists.

State teams will continue to consider specific housing-related items for inclusion in future IPs, with the decision on inclusion based on progress of work that is already underway and issues of high priority as indicated by our experience on the ground.

SME Housing Access Plan (Section XII, Subsection A, page 18)

During the first year of the SA the SME drafted a Housing Access Plan with input and agreement from State. The plan outlined a range of recommendations that were intended to inform and support the State's actions related to improving housing access, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

Progress Report:

The State has implemented many of the strategies recommended in the SME Housing Access Plan. However, the plan has been removed from the Year 5 IP, and progress is no longer tracked in this format. Instead, the most up-to-date SME recommendations are available in the SME Compliance Report online.

One recent development is that the Department along with six (6) local public housing authorities are working on MOUs for individuals transitioning out of North Dakota institutions who are eligible for a Mainstream Housing Voucher. Great Plains Housing Authority, Minot, Grand Forks and Burleigh Housing Authority have signed MOUs. The Fargo Housing Authority decided not to sign due to some local housing issues and the fact that they don't have any mainstream voucher capacity. If their situation changes, they may agree to sign an MOU in the future. Link to October 2024 SME Compliance Report

Updated Strategy 1. Development of housing needs and preferences tools that will be incorporated into LTSS Options Counseling and case management processes.

Continue to convene State Housing Services Collaborative to recommend strategies that will be effective and consider the current State economic realities, housing market, and other policy issues.

Continue to work to secure additional resources to support housing/transition efforts and build connecting points into technology platforms that are already being used in service delivery. The committee will continue to educate stakeholders about the need for these funds to build affordable and accessible housing in ND. DHHS staff continue to provide input on the annual allocation plan for the federal Low-Income Housing Tax Credit program and the Housing Trust Fund, Home Investment Partnership Program, and the ND Housing Incentive fund. **(Ongoing strategy)**

Progress Report:

In October 2024, MFP began working the Minot State University to establish a collaboration in which MFP is notified of accessible available units. To date MFP has received notification from two (2) separate large property management companies of available accessible units.

New strategy 2. Conduct a stakeholder engagement opportunity for people who live in public housing to discuss their thoughts on the current availability and functionality of affordable and accessible housing and whether the current system is meeting their needs.

Discuss what is meant by accessibility. This information will be used to inform future policy changes and long term needs for services. **(Competed December 31, 2023)**

Progress Report:

ND Housing and Finance held a stakeholder meeting on held November 30, 2023 to discuss the meaning of Universal Design so the builders requesting funding for projects understand the criteria for the allocation plan for funding.

A Universal Design Standard policy manual was created from the feedback received by stakeholders and development partners. This manual was incorporated into the 2024 Multifamily funding application round held September 30, 2024. https://www.ndhfa.org/wp-content/uploads/2024/07/UniversalDesignStandards.pdf

New Strategy 3. Sometimes people without disabilities end up renting affordable, accessible housing units instead of individuals with disabilities who need them. This can happen because the rental market is very tight and the landlords often make units available on a first come first serve basis. Aging Services will work with the ND Housing Finance Corporation and developers to devise a strategy and recommendations to help ensure that accessible, affordable housing units are available to those individuals who truly need them.

Progress Report:

See Section XII.A.Updated Strategy 1

Connect TPMs to Permanent Supported Housing (PSH) (Section XII, Subsection B, page 19)

Implementation Strategy

Updated Strategy 1. Connect TPMs to integrated community housing with community supports whose PCP identifies a need for PSH or housing that SME agrees otherwise meets requirements of 28 C.F.R. § 35.130(d) **(Ongoing strategy)**

Challenges to Implementation

Consistent gathering of data from multiple points of system entry to be able to fully understand the barriers to accessing integrated community housing.

Remediation

Housing case notes were added to the case management system. One case note identifies housing barriers upon referral and the other case note identifies assistance provided to overcome the barriers. The data will be reviewed biannually to look for trends and develop strategies to address the issues.

Progress Report:

In 2024, accessible and affordable housing is the number one (1) barrier for TPMs awaiting transition in some areas of the State. Consistent gathering of data from multiple points of system entry has helped the State to better understand the barriers to accessing integrated community housing.

See Section XII. Performance Measures

Updated Strategy 2. Research enhanced housing inventory, integrated with the ADRL system that identifies availability of housing options that may be suitable to meet the needs of TPMs who have an identified housing barrier. The inventory should include, to the greatest extent possible, information related to accessibility, affordability, availability, and tenant selection criteria as well as information related to a property's status as PSH as per the SA. Identify technology solutions and assess feasibility to serve as accessibility resource for housing locators who are working to connect TPMs to appropriate housing. The State will research options used by other states and develop a recommendation. **(Completed May 31, 2024)**

Challenges to Implementation

Complexity of consistent front end data entry that will return high quality data and cost of the system. The current ADRL database https://ndcpd.org/mfp-listings/ includes the housing inventory and will show the characteristics of attributes of the units. For example, are they accessible, affordable, allow pets, etc.

It does not update when units are rented etc. as this process would not be manageable or happen in real time. The housing facilitators help TPMs search and find appropriate housing in the community.

Remediation

Build on housing inventory already developed and maintained by MFP transition team and consider opportunities to further integrate into ADRL-based search capabilities based on the research that will be completed on other State models.

Progress Report:

See Section XII. Performance Measures

Strategy 3. Convene State Housing Services collaborative to review and offer feedback on the Low-Income Housing Tax Credit Qualified Application Plan annually, particularly as related to the incorporation of plan elements that would increase TPMs' access to affordable, appropriate housing options. **(Ongoing strategy)**

Progress Report:

The State is working with the Tax Department to organize a webinar in 2025 that talks about all of the tax breaks and programs for individuals with disability and low-income older adults.

Connect HCBS and Housing Resources (Section XII, Subsection C, page 19)

Implementation Strategy

New Strategy 1. Complete a housing coordinator crosswalk to identify the entities that offer housing facilitation and make sure these entities are working together to streamline the referral process. The intent is to have housing facilitation provided in a consistent manner statewide to better serve eligible populations. **(Completed June 30, 2024)**

Progress Report:

Link to Appendix C – MFP/TDPP Housing Facilitation Services

New Strategy 2. The State has developed a Supported Housing Services Collaborative made up of housing and community service providers, DHHS staff, and the State Housing Finance agency. The committee will be updating their goals and action steps to mitigate barriers to effective housing supports that allow eligible populations to access community integrated housing. This process will include defining challenges to implementation. **(Ongoing Strategy)**

> **Goal #1:** Ensure that Target Population Members receive housing supports identified in Person Centered Plans that are designed to support a transition to and success living in the community.
>
> **Goal #2:** Increase access to existing affordable and affordable accessible rental units through policy change and relationship development.
>
> **Goal #3:** Increase Permanent Supported Housing opportunities for TPMs by expanding capacity through rental housing development and rental subsidies.
>
> **Goal #4:** Ensure housing specialists have access to updated housing availability options.
>
> **Goal #5:** Placements to housing should be consistent with settings as defined as Permanent Supported Housing in the Settlement Agreement.
>
> **Goal #6:** Notify the SME prior to transition of any recommended placements to settings other than Permanent Supported Housing for review of the transition plan.

Progress Report:

See Section XII.A

Strategy 3. Build on the State's case management system, to ensure that we are continuing to streamline and refine the data collection process. The State will work with the case management vendor to build a report that tracks from the date of request to completion of home modification for TPMs utilizing MFP. **(Completed February 1, 2024)**

Progress Report:

Information is collected from Therap and is utilized to capture the data for reporting purposes.

Training and Coordination for Housing Support Resources (Section XII, Subsection–D - Housing Services- Page 20)

Implementation Strategy

Strategy 1. Develop training for housing support providers to know how to access various home modification resources effectively and appropriately, including assembly of funding from multiple sources and expected timelines for authorization of housing modifications. Develop new ongoing training opportunities for housing professionals/teams regarding integration of environmental modification ideas into the PCP, including resources that help professionals/teams better understand flexibilities that may be possible with reasonable modification and that help TPMs and their families and/or caregivers better understand options available to them. **(Ongoing Strategy)**

Progress Report:

The Transition Service Specialist holds monthly meetings in addition to one-on-one support for the Housing Facilitators providers.

Updated Strategy 2. Follow Medicaid policy (specifically SNF) to create guidance regarding "intent to return home," resulting in a usable resource for LTSS OC, eligibility workers, landlords, discharge planners and housing support team professionals.

"Intent to Return Home" is identified in individual service plans that involve a person's "intent" following a change in status. Some TPMs are not able to maintain their housing while temporarily in an institutional setting because of housing provider or Medicaid-related policies and requirements related to time away from a housing unit. The State intends to create educational information about "intent to return home" to add to the resources the LTSS Options Counselors and discharge planners etc., can use that includes information that needs to be communicated to SNFs to facilitate continued TPM access to monthly payments which further enable a return home. **(Partially completed April 1, 2024)**

Progress Report:

Individuals who enter a nursing home on a short term stay who have the intent to return to the community must take steps to protect their housing from being counted as an asset when determining Medicaid eligibility. Guidance in the form of a brochure has been created for use by the LTSS OC, eligibility workers, landlords, discharge planners and

housing support team professionals. The brochure is used to educate TPMs on how to maintain their housing while temporarily in an institutional setting because of HUD and Medicaid-related policies and requirements related to the allowable time away from a housing unit. The State will work on a process to help TPMs maintain their community housing by flagging the individual as someone who has an “intent to return home” and is in the facility on a short-term stay. State staff will be trained to ask the TPM or their legal decision maker if they have the required documents to ensure that they can receive housing assistance and maintain their Medicaid.

Challenges to Implementation

Complexity of underlying systems. Determining who is the party responsible to make sure the checklist is used and that all necessary steps to secure a TPMs current housing are incorporated into their discharge and transition plans.

Remediation

Involve people with expertise in federal housing and Medicaid in this initiative. Provide education and training that defines responsibilities by role.

Training has been done, but a more direct approach is needed to ensure that the SNF staff understand the importance of submitting the intent to return home form to the Medicaid eligibility unit. A meeting will be held that involves Aging Services staff, Long Term Care (LTC) Medicaid eligibility, and the State’s NF LoC review vendor to find a way to improve this process. Once new recommendations are complete education and training will be provided. **(Target completion April 1, 2025)**

Progress Report:

See Section XII. Performance Measures

Updated Strategy 3. Continue to use funds from MFP to maintain a TPMs housing while in institutional care to ensure they have adequate housing post discharge. **(Ongoing strategy)**

Progress Report:

A usable resource has been developed and provided to LTSS OC. Education on the alternative Medicaid budgeting for individuals intending on a SNF stay of six (6) month or less has been developed and presented during the annual educational sessions with SNF and hospital discharge planners. If a TPM intends to return home within 6 months of a nursing facility stay, Medicaid policy lets the TPM keep the same amount of money as if they are still in the community. This allows the TPM to continue to pay their rent and other related bills until they get home. We are working with Medicaid and the NFLoC vendor to develop and distribute information and increase awareness for individuals who have intent to return home following rehabilitation in an institutional setting.

Fair Housing (Section XII, Subsection E, page 20)

Implementation Strategy

Housing Specialists will receive in-person training on federal laws that prohibit housing discrimination against individuals with disabilities, with a particular emphasis on the Fair Housing Act and Title II of the ADA, and the Agreement's requirements.

Training is done annually with Fair Housing of ND and the ND Department of Labor. All Housing Coordinators are required to attend. **(Ongoing strategy)**

Progress Report:

The training module Housing 101 is part of the onboarding process for newly hired transition coordinators and housing facilitator and is automatically assigned.

Rental Assistance (Section XII, Subsection F, page 20)

Implementation Strategy

Strategy 1. Outline State strategy for access to rental assistance, including all resources available (ex. HUD Housing Choice voucher, Mainstream voucher, Veterans Administration Supportive Housing voucher, Rural Development rental subsidy, State rental assistance, emergency rent assistance [State or federal]). Include processes for accessing rental assistance (eligibility, referral, documentation, and determination). Information will be added to the environmental modification metric so that all information is contained in one document. **(Updated targeted completion date ~~July 1, 2024~~ April 1, 2025)**

Challenges to Implementation

Capturing information in a synthesized analysis as multiple systems are undergoing changes simultaneously.

Establishing stable funding streams that can support a state rental assistance program.

- Section XI. Subsection A. New Strategy 3. also applies to this section.

Updated Strategy 2. Expand permanent supported housing capacity by funding and providing rental subsidies for use as permanent supported housing. The 2023-2025 DHHS budget included $300,000 of State funded rental assistance for TPMs. The State will continue to discuss the feasibility of requesting permanent state funding for rental assistance in the 2025-2027 executive budget request. **(Completion June 30, 2024)**

Challenges to Implementation

Establishing stable funding streams that can support a state rental assistance program.

Progress Report:

Funding was included in the Executive Budget Request to the Legislature

See Section XII. Performance Measures

Section XII Performance Measure(s)

Number of TPMs who indicated housing as a barrier who were provided PSH.

- 84 TPMs who transitioned during this reporting period received permanent supportive housing.

Housing outcomes including but not limited to the number of days in stable housing post-transition.

- The three (3) most utilized housing facilitation services are:
  - Housing Search
  - Completion of Housing application
  - Provided education on rights and responsibilities of tenant

Number of TPMs who transitioned and diverted that received housing facilitation and resulting services accessed.

- All TPMs are offered housing facilitation services. 84 of the TPMs who transitioned and 532 individuals that are being diverted, utilized some type of housing facilitation. The larger number includes all HCBS recipients who need this support.

Number of TPMs who successfully maintain their housing in the community during a SNF stay.

- All the TPMs who transitioned during this reporting period, maintained their housing without assistance.

- Number of TPMs who receive rental assistance, including those that transition and those who are diverted.

  MFP paid rent for 50 unduplicated TPMs.

  - 27 individuals received TPM Rental
  - 32 individuals received MFP Rental
  - 8 individuals received both

In addition to rental payments for these 50 TPMs, a voucher or a rental unit leased from a project was provided to an additional 35 TPMs for a total of 85 individuals who were supported in this reporting period.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

Resources for QSPs (Section XIII, Subsection A, page 21)

Implementation Strategy

Strategy 1. Continue to use MFP capacity building funds for the QSP Hub. The QSP Hub assists and supports Individual and Agency QSPs and family caregivers providing paid and natural supports to the citizens of ND. **(Ongoing strategy funded through September 2025)**

The primary goals of the QSP Hub are to:

- Provide one-on-one individualized support via email, phone, and/or video conferencing to assist with enrollment and reenrollment, electronic visit verification, billing, and business operations to recruit and retain a sufficient number of QSPs. This will include the development of new technical assistance tools such as user guides that will be available in multiple languages. All technical assistance tools will be updated to reflect the new QSP application portal enrollment process.

- Create and maintain accessible, dynamic education and training opportunities based on the needs of the individual QSPs, QSP agencies, Native American communities, and family caregivers providing natural support services.

- Continue to develop the QSP Building Connections stakeholder workgroup and make updates to the strategic plan.

- Develop an informational support network for QSPs including developing a website, listserv, and avenues for QSPs to support one another. This will include the development of a QSP mentorship program that utilizes experienced QSPs to provide support to new QSPs, or QSPs who request individual technical assistance.

- Utilize data and evaluation to inform and improve the effectiveness of the QSP Hub.

- Establish and implement QSP agency recruitment initiatives.

Progress Report:

See Section XIII. Performance Measures

New Strategy 2. The QSP Hub with input from the state will develop a Be More Colorful recruitment video featuring a day in the life of a direct support professional/QSP. Be More Colorful is a North Dakota based marketing agency that uses interactive virtual tours to show a realistic job preview of various professions to encourage career exploration of students and adults. The career view video will be used when conducting outreach with high schools, universities, community colleges, at career fairs, and other community events. **(Completed April 30, 2024)**

Progress Report:

This project is complete. The Virtual Reality headsets have been used at various events with high school and middle school students. The web version of the 'Be More Colorful' recruitment video is also available on the QSP Hub website. Link to video

New Strategy 3. Conduct a three-pronged marketing event that includes a direct mailing, social media run of the ADRL marketing videos, and a community enrollment pop-up event in a community that is struggling to find QSPs to support TPMs. **(Completed March 31, 2024)**

The State will work with the QSP Hub to target the community of Cavalier, ND. Cavalier, ND is in northeastern ND and there is a shortage of QSPs in that area. A direct mailing postcard will be sent to eligible households that provides information about how to access services and supports from the ADRL and asks people if they are interested in helping their community by becoming a QSP. The postcard mailing includes a QR code that can be scanned and will direct people to the new QSP application portal and the QSP Hub. At the same time, we will boost the ADRL ads to social media and advertise a QSP enrollment pop-up session held in Cavalier to assist anyone who has question or wants to enroll. Data from this effort will be tracked and evaluated to see if targeted outreach like this works and could be replicated in other ND communities.

Progress Report:

The QSP Hub mailed out the post cards with a QR code linked to an informational video and enrollment information. This included two days of in-person pop-up sessions in Cavalier, ND that offered enrollment support using the new QSP web portal. There were no attendees at these enrollment opportunities. Because this strategy was not successfully it will not be repeated in Year 5.

New Strategy 4. Partner with the QSP Hub to offer access or create training videos or live training events that will expand the business acumen of the QSPs especially agency QSPs. Topics for the videos may include leadership courses, completing cost reports, effective marketing, employee recruitment, engagement, and retention. **(Ongoing strategy funded through September 2025)**

Progress Report:

The QSP Hub completed and made available over 35 different resources in video format as well as hosted a variety of learning sessions and created printable resource materials.

The QSP Hub has a list of ongoing topics and is continuously developing new content as topics arise.

Updated Strategy 5. Developing partnerships with ND high school and college student career counseling services to discuss the possibility of placing individuals working on a CNA certification or those studying to be an RN, OT, PT etc., with QSP agencies to gain experience and coursework credits while providing HCBS. Students could complete a placement in the community and could be hired as employees or work toward credit hours on their degree.

Progress Report:

The QSP Hub has partnered with UND and the Scrubs Academy and Scrubs Camp events. The QSP Hub participated in two (2) events this year with Scrubs as well as two (2) different high school career fairs. The QSP Hub is working to get into the schools to present to classes in this upcoming year.

The updated QSP Hub work plan will focus on developing partnerships with ND high school and college student career counseling services to discuss the possibility of placing individuals working on a CNA certification or those studying to be an RN, OT, PT etc., with QSP agencies to gain experience and coursework credits while providing HCBS. Students could complete a placement in the community and could be hired as employees or work toward credit hours on their degree. **(Estimated implementation date September 1, 2025)**

Updated Strategy 6. Prioritize outreach at community events i.e., street fairs, college fairs and job fairs to reach more people who are not already part of the HCBS delivery network.

Progress Report:

Event	Date	# Reached
Coffee and Conversation (GF Job Services)	7/8/2024	8
Talent Tuesday (Fargo)	7/23/2024	31 (booth) 81 total
Scrubs-Devils Lake	7/30/2024	26
Coffee and Conversation (GF Job Services)	7/8/2024	8

Workforce Wednesday – Job Services (Grand Forks)	8/7/2024	15
Workforce Wednesday – Job Services (Grand Forks)	9/4/2024	13
University of Jamestown-Block Party	8/29/2024	500+
Greater Grand Forks Job Fair	9/12/2024	85+
Job Service Event – Devils Lake	9/25/2024	25 +
Job service Event Williston	9/19/2024	30+
Parkinsons event	9/19/2024	140
University of Jamestown Career Fair	October	150+
Northern Plains Conference	October	175

Updated Strategy 7. Implement a 3% inflationary rate increase for all HCBS services that was approved in the 2023-2025 DHHS budget. **(Complete July 1, 2024)**

Progress Report:

Rate increases were applied to all QSP rates effective July 1, 2024.

Updated Strategy 8. The State will implement changes to the rates for HCBS that were approved during the 2023-2025 legislative session. Family Home Care will change from a daily maximum of $49.56 to $72.50 per day. Individual Adult Foster Care will increase from

a maximum daily rate of $99.07 to $150.00 per day. Full implementation required regulatory authority changes that included approval of a Waiver amendment by CMS. **(Completed January 1, 2024)**

Progress Report:

Service specific rate increases were applied to the QSP rates effective January 1, 2024.

Updated Strategy 9. Finalize the development and implementation of a provider enrollment portal that will be made available to agency and individual QSPs. The system, which will replace the current paper process, will ask a series of questions, and then intuitively guide the user to the services they are eligible to provide. The portal will allow providers to enter and save their information eliminating the need to provide information multiple times.

The system is rooted in customer service and includes short video tutorials and tool tips to help answer questions quickly which will increase the likelihood of completing the application process in the first attempt. All required enrollment training such as the QSP Fraud Waste and Abuse training and the QSP orientation is contained within the system. The system will also include a screening tool that will allow agency QSPs to check all the required websites to screen employees who will work with individuals who are receiving State or federally funded HCBS. The system will also be used for reenrollment and to add or change a provider's personal information, service array, or service territory.

State staff are currently working with an IT vendor to finalize the QSP enrollment portal. The project started in July 2023 and has a 16-week implementation goal. The system allows for a third party to help an individual who may lack capacity to complete the application process themselves online. The QSP Hub will have access to the system and can provide individual technical assistance upon request. **(Complete January 3, 2024)**

The online provider enrollment portal is currently available to agency and individual QSPs. The system is used for initial QSP enrollment, revalidation and maintenance of provider information and service array information. **(Ongoing strategy)**

Progress Report:

The QSP Hub has access to the enrollment system and provides assistance daily to providers seeking technical assistance. Types of assistance provided:

- creating a user account
- starting and completing an application
- technical assistance and trouble-shooting the application process
- support case managers and providers with initiating an application
- maintenance request and support
- claiming accounts
- checking application status

Updated Strategy 10. Create a centralized QSP matching portal in cooperation with ADvancing States to replace the current QSP online searchable database.
The new system will be implemented with State specific modifications to a national website called Connect to Care system formally referred to as ConnecttoCareJobs to significantly improve the capacity of TPMs in need of community services to evaluate and select individual and agency QSPs with the skills that best match their support needs.

The system will have the capacity to create reports, be updated in real time, and available to HCBS case managers and others online. It will allow QSPs to include information about the type of services they provide, hours of work availability, schedule availability, and languages spoken. The system will interface with the QSP portal and will receive daily updates of new QSPs and changes to current QSP information so information in both systems is always current.

The State will work with the QSP Hub to hold training sessions with QSPs to help them develop their online profile and marketing skills in the system so they can better advertise themselves to potential clients. **(Partially complete ~~December 11, 2023~~ launched January 2024)**

Progress Report:

The State will continue to refine and fully implement a centralized QSP matching portal in cooperation with ADvancing States. The system is currently in place and replaced the former QSP online searchable database. The new system was designed with State specific modifications to a national website called Connect to Care formally referred to as ConnecttoCareJobs to significantly improve the capacity of TPMs in need of community services to evaluate and select individual and agency QSPs with the skills that best match their support needs.

The system has the capacity to create reports, be updated in real time, and available to HCBS case managers and others online. It will allow QSPs to include information about the type of services they provide, hours of work availability, schedule availability, and languages spoken. The system will interface with the QSP portal and will receive daily updates of new QSPs and changes to current QSP information so information in both systems is always current.

The State will continue to work with the QSP Hub to hold training sessions with QSPs to help them develop their online profile and marketing skills in the system so they can better advertise themselves to potential clients. **(Ongoing strategy)**

See Section XIII. Performance Measures

Updated Strategy 11. Continue to pay up to $250,000 for the CQL accreditation fees for additional agencies who are willing to develop residential habilitation and community-support services for the HCBS Waiver serving adults with a physical disability or adults 65 years of age and older. Deferring costs for accreditation will increase capacity to provide the 24-hour a day services needed to support TPMs with more complex needs in the

community. **(The State has funding available through June 30, 2025 or until funds are expended)**

Progress Report:

See Section XIII. Performance Measures

Updated Strategy 12. The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population. The plan will include meeting directly with the leadership of specific healthcare agencies like hospitals and SNFs and their provider associations to directly ask for their assistance in providing HCBS to TPMs that live in their service area. **(Updated Target completion date ~~July 1, 2024~~ August 1, 2025)**

Progress Report:

The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population in "service dessert" areas like Jamestown and Dickinson, ND. The plan may include meeting directly with the leadership of specific healthcare agencies like hospitals and SNFs and their provider associations to directly ask for their assistance in providing HCBS to TPMs that live in their service area. The Aging Services Section Director will work with the Public Information officers to design an outreach letter that can be used to communicate with SNFs or health systems who may be interested in becoming a QSP. In addition, the State will continue to provide ongoing group and individualized training and technical assistance to SNFs that express interest in learning about HCBS. The State will also brainstorm ways to use social media to hire direct support professionals for a specific TPM. Some of the advocates have reported good results from this approach.

Updated Strategy 13. Support start-up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Four (4) additional incentive grants will be awarded in Year 4 of the SA in amounts up to $50,000 each based on the priority of need of the services the agency will provide. **(Grants awarded April 01, 2024)**

Progress Report:

- Four (4) QSP grants were awarded, each for $50,000.
    - Two contracts were extended, and the providers are in the process of completed the contracts.
    - Two contracts were terminated due to the providers' inability to meet the terms of the contract.
- In addition, the State will support start-up and enrollment activity costs for existing QSPs to establish or expand their ability to provide non-emergency medical transportation, non-medical transportation, and community integration activities for HCBS recipients by providing grants to purchase new or used accessible vehicles. These grants will be available to HCBS providers in good standing, who have been

enrolled for a minimum of two (2) years and those who are currently providing services to an HCBS recipient. The State is currently determining the amount of funds available and number of grants that will be awarded. **(Grants awarded by May 01, 2025)**

New Strategy 14. To continue to ensure timely enrollment and revalidation of QSPs, the State has decided to bring QSP enrollment duties inhouse. The State will be hiring five (5) temporary QSP enrollment staff that will work under the supervision of the Medical Services QSP Enrollment Coordinator. The new staff will use the QSP portal to compete all aspects of QSP enrollment. QSP enrollment staff will also be responsible to manage the Connect to Care formally referred to as ConnecttoCareJobs QSP registry, which will interface with the QSP portal to ensure provider information is accurate and up to date. The goal is to complete all new enrollment applications within 14 calendar days of receipt of a complete application. The QSP enrollment staff will also begin processing new provider revalidations and provider information maintenance requests once the QSP portal is complete. **(Implemented January 03, 2024 and ongoing strategy)**

Updated Strategy 15. Work with a vendor to complete a project to assess the current training requirements and structure for HCBS providers working in Aging Services, Developmental Disabilities Services, Autism Services, and Behavioral Health Services. The vision for the project is to identify and establish innovative workforce training strategies to meet provider needs and improve the quality of life for North Dakotans with disabilities.

The goals of the project are to:

- Identify and address the needs of providers and caregivers,
- Improve the quality of training services by establishing strategic training protocols,
- Establish a standardized set of training policies and procedures across the various services and systems,
- Identify core qualifications for all providers to develop and maintain,
- Improve collaboration and coordination among State agencies and stakeholders.

Progress Report:

DHHS partnered with an independent consulting firm to perform the assessment and develop recommendations to implement pathways for an innovative workforce training strategy. As part of the assessment, they asked key stakeholders to complete a web survey and to participate in discovery sessions to provide perspective and inform our understanding of both the current workforce training structure, as well as the needs and desires for the future. The State recently got approval from ND Information Technology

Division to use the current ConnecttoCare platform to house a training curriculum for providers. The State will now begin the process to choose the type of curriculum that will be used for all HCBS providers. **(Target completion date September 01, 2025)**

Updated Strategy 16. Each year many individual QSPs enroll to provide care to one person who may be a relative or a friend who needs assistance. When the individual they serve passes away, moves to a SNF etc., they often stop being an individual QSP. Some of these QSPs, if asked, may have enjoyed the caregiving role and would be willing to serve other individuals in need of care. Retaining these QSPs would increase the State's capacity to serve TPMs. Once the new QSP enrollment portal is complete, State staff will work with the staff from the QSP Hub to design an effective outreach campaign to attempt to retain QSPs who originally enrolled to serve a family member or friend. QSPs who have disenrolled in the past six (6) to nine (9) months and were in good standing with the DHHS will be targeted for this project. Any QSPs who agree to reenroll and help public pay clients will be offered a recruitment bonus paid with funds from the 9817 10% plan. The State will track the number of individuals we reached and if any of them enrolled to provide care. We will also add language to the QSP handbooks to make sure people are aware of the ongoing opportunity to be a QSP after their family caregiver journey ends. **(Partially Completed September 24, 2024)**

Progress Report:

The State sent letters to a targeted group of individuals recommended by HCBS Case Managers as former QSP family caregivers who had provided excellent care to their loved ones. These individuals resided in areas of the State considered "service deserts," such as Jamestown, ND. However, no responses were received, and as a result, the Department will not fully implement this strategy.

Instead, the QSP Hub has developed an Exit Survey, emailed monthly, to gather insights from QSPs who have voluntarily left the profession. The goal is to identify key factors that could help retain or encourage the return of QSPs. The first survey was distributed in September 2024, and since that date 85 exit surveys have been distributed and 10 have been returned. The data will be compiled and analyzed after six months.

New Strategy 17. Update ND Admin code 75-03-23 to require a representative of an enrolled QSP agency or an individual QSP to complete a department approved Qualified Service Provider orientation prior to initial enrollment. The State is working with staff from the QSP Hub to create the orientation. The orientation will be recorded as a series of short videos or an eLearning module that will be embedded in the new QSP enrollment portal. QSPs who are revalidating enrollment and QSP applicants will be required to watch the orientation as part of the enrollment process. The new system will track if the videos were watched in their entirety. **(Completed January 1, 2024)**

Progress Report:

This project has been completed. All content was drafted and shared with the "HHS technology team". This team produced the content and it is embedded into the web portal

as a part of the enrollment requirement process. All QSP applicants are required to complete this training in order submit an application.

New Strategy 18. Use funds included in the 2023-2025 DHHS budget to pay a stipend to Agency QSPs who are willing to designate on-call staff that would be available to assist TPMs in the event of an emergency or if the regularly scheduled provider is unable to complete their shift. The State will be working through the procurement process to request proposals from Agency QSPs interested in creating or sustaining an on-call QSP system in their organization. **(Updated target completion date ~~February 1, 2024~~ June 1, 2025)**

New Strategy 19. Use feedback gleaned from the QSP Agency and Native American QSP agency stakeholder meetings to offer financial incentives to encourage providers to serve TPMs with high care needs and TPMs and other individuals whose need for care is intermittent. The State will issue a request for proposals that will allow QSP agencies and agencies willing to become a QSP to create a proposal that demonstrates their plan to serve this growing population.

The scope of service could cover different options like requesting payment for employee travel, training, wait time between serving individuals and retainer wages to keep staff when there is turnover in 24-hour cases. The scope could also include incentives for Agency QSPs to seek additional training for their staff in the provision of services to individuals with dementia, TBI, or behavioral health issues. The funds could also be used to contract with professionals to assist them in developing individual program plans that will mitigate known risk factors to living in the most integrated environment. **(Not completed)**

Progress Report:

The State has not moved forward with this project. Instead, it has requested a targeted rate increase for services commonly provided to individuals with intermittent needs. Funds were included in the 2025-2027 Executive Budget request to increase rates for homemaker, chore, personal care, respite, supported employment, transitional living, non-medical transportation (escort), companionship, and supervision services.

If approved, the rate increase will standardize payments for similar services. For example, personal care and homemaker services will be reimbursed at the same rate, which is not currently the case. The State believes that aligning these rates will simplify the process and encourage more providers to offer these essential services. This strategy aligns with the recommendations from the QSP Rate Study to simplify the rates for similar services.

Critical Incident Reporting (Section XIII, Subsection B, page 21)

Updated Implementation Strategy

The State will provide ongoing critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The State

QSP handbook includes current reporting requirements. The State will also work with staff from the QSP Resource Hub to develop marketing of ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. The QSP Hub assists in making QSPs aware of training opportunities, but the training content is developed and delivered by an Aging Services nurse administrator. **(Ongoing strategy)**

Progress Report:

QSP training was provided on the following dates:

- March 28, 2024 with 41 attendees
- June 28, 2024 with 36 attendees
- September 30, 2024 with 36 in attendees

Education was provided to transition coordinators on August 21, 2024 as well as to basic care and specialized basic care facility administrators at the Long Term Care Convention on May 10, 2024.

SME Capacity Plan (Section XIII, Subsection C, page 21)

Implementation Strategy

During the first year of the SA the SME drafted a Capacity Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving capacity, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

Link to October 2024 SME Compliance Report

Progress Report:

The State has implemented many of the strategies recommended in the SME Capacity Plan. However, the plan has been removed from the Year 5 IP, and progress is no longer tracked in this format. Instead, the most up-to-date SME recommendations are available in the SME Compliance Report online.

Capacity Building (Section XIII, Subsection D, page 21)

Implementation Strategy

Updated Strategy 1. The Environmental Modification workgroup will continue to analyze and add information to the matrix that describes which services are working, which services are underutilized and will work on strategies to create awareness and improvements of these programs. The Environmental Modification workgroup developed a

focused approach to evolving North Dakota's approach to home modifications and analyzed barriers experienced by TPMs as identified in PCPs and while delivering transition and diversion services.

Supplemental information is available from data collected in the State case management system with 2-3 focus groups that include HCBS case managers, LTSS Options Counselors, housing facilitators and transition coordinators.

Inventory options that are available to address most common barriers to housing and explore options that are specific to hardest-to-resolve barriers to housing. Include skilled assessment of modification needs in this analysis as it is a precursor to effective delivery of this intervention.

Recommendations related to highest priority areas will inform decisions about modifications that may be needed in policy, rule, or law. **(Ongoing strategy)**

Challenges to Implementation

Effectively bringing together people who represent disciplines that have not traditionally worked collectively around the topic of home modification.

Progress Report:

One of the biggest barriers is that under the Fee for Service programming, funds for building supplies needed to complete the project cannot be paid for prior to completion of the project. This causes a barrier for some modifications as the contractors cannot afford the overhead cost of construction without the building supply expenses paid.

The State received CMS approval to work with ND Assistive on developing on the Home Modification Capital Fund to have ND Assistive oversee the project to completion.

Strategy 2. The State will continue to provide ongoing group and individualized training and technical assistance to SNFs that express interest in learning about HCBS. The State will continue to conduct webinars starting to inform the healthcare community about the potential benefits of providing HCBS. Individual meetings will also be conducted to provide support to any organization interested in expanding their service array upon request. **(Ongoing Strategy)**

Progress the Report:

In Year 4 of the SA, one (1) SNF and one (1) memory care facility showed interest in providing HCBS. The State met with their directors and staff to explain the process.

The SNF ultimately withdrew after its board declined to complete the federally required ownership and controlling interest form for Medicaid enrollment. Despite education from the Agreement Coordinator the board was not comfortable disclosing their social security numbers on the required form.

Meanwhile, a local memory care facility remains interested in offering HCBS to individuals with dementia at home. They are developing an internal plan and know they can reach out with any questions.

Strategy 3. Increase the capacity for providers to serve TPMs on Native American reservation communities by continuing to partner with Tribal nations and to request funds for the Money Follows the Person-Tribal Initiative (MFP-TI).

The MFP-TI enables MFP state grantees and tribal partners to build sustainable community-based long-term services and supports specifically for Indian Country.

The State will continue to support the development and success of Tribal entities who enroll as QSPs to provide HCBS in reservation communities by gathering feedback to improve processes, providing technical assistance, training, and staffing cases to ensure TPMs have the services they need to live in the most integrated settings appropriate. Mandan, Hidatsa, Arikara Nation; Standing Rock Sioux Tribe; and Turtle Mountain Band of Chippewa Indians are currently participating. **(Ongoing Strategy)**

Progress Report:

MFP contracts with Turtle Mountain, Home Instead for south segment of MHA nation, and NDSU for general tribal liaison support. Other Tribal nations can participate upon request. Turtle Mountain is enrolled as a QSP agency and is currently providing in-home care to tribal members. Home Instead is also providing direct care. These are tribal owned agencies that employe tribal members to serve native American elders.

New Strategy 4. Increase the capacity for providers to consult accessibility experts when implementing HCBS such as environmental modification by providing funding to the CILs to allow more of their staff to be trained as accessibility experts.

Challenges to Implementation

Determining what training is most appropriate to ensure staff have the knowledge necessary to provide reliable recommendations about accessibility.

Remediation

The State will work with the CILs and other experts to determine the level and type of training required to ensure well trained staff.

Progress Report:

The State is working with the Housing facilitators to determine the level and type of training required to ensure well trained staff.

This will be included in the Minot State Contract in 2025. A meeting is scheduled with the Minot State Contract team to collaborate with the development and implementation.

MFP met with Lakeside Customs who is interested in providing home modifications and carries an Aging in Place Certification.

The State seeks to increase the capacity for providers to consult accessibility experts when implementing HCBS such as environmental modification by providing funding to the CILs or other organizations to allow more of their staff to be trained as accessibility experts. Grants will be awarded to allow approved agency staff to complete ADA Coordinator Training Certificate Program or other similar training. **(Target completion date July 1, 2025)**

New Strategy 5. The State submitted a proposal to CMS and has secured the legislative authority to use the temporary 10% increase to the FMAP for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs.

The plan includes the following strategies that directly impact TPMs covered in the SA:

- Developing a pilot program that supports both the recruitment and retention of the direct care workforce in the HCBS industry.
- Engage workforce partners to identify financial incentives that would be meaningful to members of the workforce and impactful in terms of overall workforce availability.
- Consider targeted incentives for specified service types (ex. respite), enhanced training/endorsements, duration of service, and complexity of care.
- Work to enhance access to the full range of environmental modifications that would help people live successfully in home or community settings.
- Work with a consultant to identify program adjustments that will broaden access to home modification resources, including examining requirements that define who can provide construction-related services and program definitions that consider assistive technologies, and equipment.
- Consider incentives for builders who are willing to engage as a home modification provider.
- Develop training for HCBS case managers and housing facilitators to appropriately access various environmental modification resources. **(Ongoing strategy through ~~September 2024~~ December 2025)**

Progress Report:

The State submitted a proposal and continuously updates the plan approved by CMS and has secured the legislative authority to use the temporary 10% increase to the FMAP for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs.

The plan currently includes payment for the following strategies that are ongoing and have direct impact on TPMs covered in the SA:

- QSP Rate Augmentation fund
- Peer Supports project for TPMs

- Hospice and Home Care Grant
- ConnecttoCareND implementation
- Companionship services
- QSP Enrollment Portal
- Marketing the ADRL
- Workforce training and learning management system integration
- Behavioral health training for HCBS case managers and QSPs
- Capacity incentive grants

New Strategy 6. Develop a "Lunch and Learn" webinar with an environmental modification provider who has experience providing environmental modification services to Medicaid waiver participants in ND and other states. The webinar will highlight how the provider has worked within the constraints of the Medicaid authorization and claims submission system to successfully serve TPMs who need this service to live in the most integrated setting. The webinar would be targeted toward the construction and home remodeling industry in ND. The session would be recorded and could be used as a future marketing tool to explain how providing environmental modification services to the Medicaid eligible population could be beneficial to their business. **(Target completion date ~~April 1, 2024~~ December 31, 2025)**

Progress Report:

The State has not yet secured a vendor willing to conduct the webinar. State staff will be attending a Home Builders event, and we are hoping to create relationships with individuals in this industry to further advance access to environmental modification that will help TPMs remain in their home.

New Strategy 7. Provide behavior intervention consultation and supports to direct service providers. The State is aware that oftentimes it is difficult to find HCBS providers who can, and will, serve clients with behavioral health needs. Strategies to increase these services could include establishing resources for QSPs and other HCBS providers to access, that would create behavior intervention plans, helping staff high need/high complexity cases, and offering consultation to in-home providers as needed. A request for proposal will be issued and the State will work through the procurement process to secure a vendor **(~~Target completion date November 30, 2023~~ Ongoing strategy)**

Progress Report:

The State has decided not to pursue procuring a single vendor for statewide behavioral intervention services, as the number of cases does not justify the request for proposal process. Instead, the State has identified a qualified vendor willing to provide behavioral intervention consultation to support providers serving individuals with behavioral health needs. The agency will enter into a provider agreement, allowing the vendor to serve clients statewide via telehealth. Additionally, the vendor will conduct a series of webinars focused on therapeutic response.

Section XIII. Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

- The QSP Hub provided support for 5,189 activities. Activities include phone calls, emails, NPI assistance, education and training. A break-down of these activities indicates that the QSP Hub specifically helped:
    - individual and agency providers 1,166 times
    - Individual Qualified Service Provider: 772 times (totaling 3,017 activities),
    - Family Home Care/Family Personal Care providers if they specified: 244 (totaling 1,004 activities)
    - Agency: 200 (Totaling 817 activities)

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation.

- There were 15 QSP agencies assisted with CQL accreditation

Number of new agencies enrolled as providers.

- A total of 35 agencies enrolled as providers during this reporting period.

Number of agencies that stopped providing services.

- A total of six (6) agencies stopped providing services during this reporting period.

Number of new independent QSPs enrolled as providers.

- A total of 337 individuals enrolled as provider during this reporting period.

Number of independent QSPs that stopped providing services.

- A total of 101 individuals stopped providing services during this reporting period.

Rate increases effective January 1, 2024.

- A rate increase was implemented for dates of service January 1, 2025 and forward.

Number of QSPs and individuals trained to Connect to Care system formally referred to as ConnecttoCareJobs by February 29, 2024.

- Training for the Connect to Care platform has been recorded and is posted on the HHS website as well as the QSP Hub Website, therefore it is not

possible to track the number of views. Once the platform is live and being used, the QSP Hub will work with HHS to develop ongoing training as needs arise.

Number of SNFs that have enrolled to provide HCBS.

- Two (2) SNF has enrolled to provide HCBS

SA Section XIV. In-Reach, Outreach, Education, and Natural Supports

Responsible Division(s)

DHHS Aging Services

In-reach Practices and Peer Resources (Section XIV, Subsection A, page 22)

Updated implementation Strategy

Strategy 1. State staff will conduct annual group in-reach presentations at every SNF in ND and ensure a consistent message is being used throughout the State. State staff will schedule and advertise a follow up visit at the facility to give TPMs additional time to process the information and ask any follow up questions. **(Target complete date December 13, 2024 and ongoing)**

Progress Report:

See Section VII.D. Strategy 3

Strategy 2. Continue to conduct LTSS Options Counseling with individuals to identify TPMs and provide information about community-based services, person-centered planning, and transition services to all TPMs and guardians, who are screened for a continued stay in a SNF.

TPMs are identified when they are referred for a long-term stay at a SNF. The NF LoC determination screening tool is required to be submitted for Medicaid serves as the referral. The State receives a daily report of individuals who have recently screened. State staff are required to conduct the visits within 10 business days of the referral.

If a TPM chooses HCBS, they are referred to the MFP transition coordinator who assembles the transition services team to begin person-centered planning. The transition team consists of the MFP transition coordinator, HCBS case manager and a housing support specialist.

If the TPM is not initially interested in HCBS they are asked if they want to receive a follow up visit, provided written information about HCBS and the contact number of the case

manager. If they decline a follow-up visit, they are provided written information and the contact information of the case manager and are informed that Aging Services staff will make a visit on an annual basis to complete the person-centered planning process. TPMs are currently asked to indicate in writing whether they received information on HCBS. **(Ongoing strategy)**

Challenges to Implementation

TPMs will be seen by the facility case manager/ LTSS Options Counselor when initially referred for a long-term stay in a SNF. Current TPMs living in a SNF will be seen annually in the month in which they were currently determined eligible for a SNF. Because it will take time to see all TPMs in a SNF there may be

individuals who would benefit from knowing about HCBS options prior to their scheduled visit.

To ensure that TPMs understand that they can contact a LTSS Option Counselor at any time if they want to discuss options to receive care in the community a special emphasis will be made to help the TPM understand how to reach out.

Remediation

LTSS Options Counselors are required to conduct ongoing group in-reach visits to each SNF at least once per year. Providing group in-reach opportunities will help ensure that TPMs, families, and guardians will have a chance to learn more about HCBS and the benefits of community living. State staff will schedule and advertise a follow up visit at the facility to give TPMs additional time to process the information and ask any follow up questions.

Progress Report:

The LTSS OC continue to provide written information and their contact information during their initial and annual visits with TPMs and are now required to document in the care plan that the date the individual was provided this information.

To ensure that all Medicaid-eligible individuals, including those applying for Developmental Disability (DD) services through the DD intake system, have access to information about all HCBS options they may qualify for, the DD Section will establish a process to inform eligible individuals about the State's HCBS coverage during the initial DD intake. Information will also be provided annually thereafter. The DD intake process will include new materials outlining the full range of HCBS programs administered by the DD Section, the 1915(i) waiver, and Aging Services. Additionally, the DD Section will work with the vendor to update the case management system to integrate this information into the intake process. A section will also be added to the individual service plan for individuals and guardians to sign, confirming receipt of this information. **(Target implementation date July 1, 2025)**

Updated Strategy 3. Procure an entity that can serve as a Peer Resource Center in ND. The Peer Resource Center will serve as a centralized place for referral. It will establish a process and requirements for peer support training and reimbursement. It will facilitate appropriate and timely connections between peer support specialists, individuals, and families who would benefit from this type of service.

Resource Center staff will develop specific expertise that gives TPMs across the lifespan who are interested in transitioning to the most integrated setting appropriate, and those who want to remain in their current home environment but also need available services and support to do so. It will create the opportunity to connect with a peer who has lived experience navigating and utilizing HCBS**. (Not completed)**

Challenges to Implementation

MFP capacity building funds will cover costs related to staffing, training, and travel for a two-year period.

Remediation

The State will use ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds.

Challenges to Implementation

The State needs to accommodate requests for peer support prior to the Peer Support Resource Center being established.

Remediation

The CILs have agreed to take referrals for peer support and match TPMs with individuals living and receiving services in the community who can share their lived experience.

Progress Report:

The State has decided not to establish a peer support resource center at this time. Instead, we will partner with Independence, Inc. Center for Independent Living to provide peer support to TPMs who are transitioning. This partnership will offer individuals the opportunity to connect with someone who has lived experience successfully transitioning from a skilled nursing facility to community living with supports. Peer support will be integrated into the transition team established when a TPM requests a transition. The State believes this approach will effectively introduce peer support into the process, helping TPMs build relationships with peer support professionals, increasing acceptance of the transition, and ultimately leading to safer and more successful outcomes. If this process works well, we will create similar services in the other CIL territories **(Target completion date of December 1, 2025)**

Communication Accommodations (Section XIV, Subsection B, page 22)

Implementation Strategy

The State will make accommodations upon request for TPMs whose disability impairs their communication skills and provide communication in person whenever possible.

The ADRL intake process includes questions to assess communication needs. The State updated the LTSS Options Counseling referral process to include similar questions. If accommodations are needed the State, hospital, or SNF will provide the necessary accommodation as required. Individual accommodations may include auxiliary aides such as interpreters, large print and Braille materials, sign language for the hearing impaired, and other effective methods to deliver appropriate information to TPMs. The State will update the ADRL and DHHS website to include information on how to request accommodations. **(Ongoing strategy)**

Progress Report:

See Section XIV. Performance Measures.

Communications Approaches (Section XIV, Subsections C & D, page 22)

Implementation Strategy

Updated Strategy 1. Continue to implement a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media at least three (3) times in Year 4 of the SA and will provide public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. Campaign will also include providing education to those parties that recommend SNF care to TPMs. This includes health care professionals/staff who are most likely to be in regular contact with TPMs and potential TPMs prior to requests or applications for NF admissions, such as geriatricians, primary care physicians serving a significant number of elders. State staff will also staff information booths at community events and will make themselves available for media requests and to present information about HCBS at stakeholder meetings and virtual and in-person conferences across the State. **(Ongoing strategy through ~~December 13, 2024~~ December 31, 2025)**

Progress Report:

A public service announcement (PSA) campaign for the ADRL ran in the following months of 2024:

- January – 1,611 calls
- April – 1,403
- July – 1,368
- October – 1,527

The average number of calls to the ADRL during the four (4) months of the campaign is 1,477 per month. The average number of calls per month during the remaining eight (8) months is 1,146. The PSAs resulted in a 29% increase in calls per month during the campaign.

Respite Services (Section XIV, Subsection E, page 22)

The State will use an additional $250,000 of supplemental grant funds that were recently awarded to enhance, expand, improve, and provide supplemental respite services and education to family caregivers in ND with resources provided through the Lifespan Respite Care Program: State Program Enhancement Grant and other State and Federal funds. **(Grant awarded August 1, 2024)**

Progress Report:

Medicaid eligibility information is not gathered for this program therefore, it is not possible to determine if individuals are TPMs. Respite service hours were provided through the Lifespan Respite Care Voucher Program to caregivers who provided care for individuals over the age of 21.

Three respite grants were awarded to agencies who are going to start providing respite services or expand their respite operations for family caregivers. Two of the providers are trying to start and adult day center. One will be located Grand Forks, and the other one will be in Fargo.

Accessibility of Documents (Section XIV, Subsection F, page 23)

Updated Implementation Strategy

The State will continue to work with the DHHS Civil Rights Officer and the ND Department of Information Technology to review all printed documents and all online information available on the USDOJ Settlement page of the DHHS website to ensure compliance with this SA.

The DHHS Legal Advisory Unit and the Civil Right Officer are discussing bringing in a third party vendor to update the website and printed documents and make the online information accessible. **(Ongoing strategy)**

Progress Report:

A workgroup has been developed within DHHS in January 2025 to collaborate with other divisions about website document accessibility.

Section XIV. Performance Measure(s)

Number of SNF residents who attended group in-reach presentations at each facility.

- There were 75 annual SNF presentations completed in 2024 with 895 individuals in attendance.

Number of referrals for peer support and outcome.

- Three TPMs have been offered peer support and all have declined to participate. Peer supports would be provided by the behavioral health peer support providers.

Number of TPMs who requested and received a communication accommodation.

- There were 109 TPMs who requested communication accommodations.

Number of TPMs who access respite and the hours provided.

- A total of 1,582 respite service hours were provided to 25 caregivers.

Number of individuals served in the CAPABLE program.

- Fifteen (15) individuals enrolled, six (6) were established consumers, and nine (9) were new consumers during this reporting period.

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS Aging Services

Methods for Collecting Data (Section XV, Subsections A, B, C & D, pages 23-24)

Implementation strategy

Provide the USDOJ and SME biannual reports containing data according to the SA. The State will retain all data collected pursuant to this SA and make it available to the USDOJ and SME upon request. The State will retrieve summary and aggregate data from a variety of sources including the case management system, MMIS data warehouse, and provider enrollment.

Updated Strategy 1. Continue to contract with a vendor to maintain and enhance the case management system that was fully implemented August 1, 2022. **(Target completion date December 13, 2024, and ongoing strategy)**

Progress Report:

State staff meet weekly with the vendor and the following enhancements were completed during Year 4 of the DOJ SA.

- Implemented an electronically interface to receive MFP referrals submitted to the ADRL.
- Improved the functionality of the user home page for case managers.
- Implemented an electronic system documentation process for QSPs,
- Added helpful system generated referral alerts and reminders for users.

Updated Strategy 2. Design a method to analyze the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the number of services available to TPMs across the State. A pilot project will be developed that looks at services in a few counties to determine what can be gleaned from this information and if it warrants expanding the data pool to add additional counties and services.

Challenges to Implementation

Ensure that the data analysis and conclusions drawn from the proposed pilot project are designed to account for individual circumstances (hospitalization, provider changes, delayed billing etc.) that may impact how a TPM uses the services authorized in the PCP.

Remediation

The State will work with the case management system vendor and the US DOJ, SME, and other experts to create a report that will produce reliable results that may assist the State in creating additional strategies to successfully implement the requirements of the settlement agreement. **(Target completion date June 1, 2024 received data from UND December 2024).**

Progress Report:

With the assistance of the Senior Research Analyst for the ND HealthCare Workforce Group at UND the State designed a method to analyze the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the number of services available to TPMs across the State for the study period of State fiscal years 2022-2023 (July 1, 2021 – June 30, 2023). The study included Medicaid beneficiaries with 24 months of continuous coverage, or the duration of the two state fiscal years. Anyone who died during the study period, or who did not have continuous enrollment was removed from the study group.

Beneficiaries who met the study group criteria were screened for the presence of one or more of the procedure codes listed below. Beneficiaries who met enrollment

and procedure code criteria were matched to the authorization file. The claim units from the service file were summed and compared to the authorized services used.

Included services:

- Homemaker (S5130)
- Personal Care (T1019, T1020, S5100, S5102)
- Residential Habilitation (T2016)
- Community Supports (S5126)

The State received preliminary data and determined that further refinement of the homemaker and personal care data is necessary to ensure accurate calculations. The issue arises with group authorizations, where multiple QSPs are authorized to provide the same services to a TPM within the same period. Sharing units among multiple QSPs is common practice, as it allows two or more providers to share caregiving responsibilities, ensuring continuous coverage and a backup plan if one QSP cannot cover a shift.

In the State's case management system, when multiple QSPs are authorized to serve the same TPM for the same dates, a group service authorization is created to represent the shared overall units. Technically, each provider has their own authorization showing access to the full authorized units in case they really need to provide all the care because the other two QSPs are unavailable. However, the case management system groups these authorizations to indicate that only the total authorized units—not multiple sets of the full amount—are available. For example, if a TPM is authorized for 70 units of homemaker services per month, these units may be shared among three (3) providers. Each provider receives an individual authorization for 70 units in the case management system, but they are grouped to limit the providers collectively to the 70-unit maximum.

The challenge arises when these authorizations transfer to MMIS, which does not recognize group authorizations. As a result, MMIS reflects that the TPM has access to 210 units instead of the intended 70. Consequently, the MMIS data used to calculate the units authorized versus units used inaccurately shows that the TPM only utilized 70 of 210 units, significantly impacting the overall total of units used. The chart below illustrates draft homemaker data, highlighting the need for further refinement to ensure accurate data elements and reporting.

Draft Homemaker Data

Procedure	Authorization Class	All Authorizations	
		Number	%

S5130 Homemaker	Authorizations	4,325	
	Authorized Services	723,670.50	
	Services Used	398,844.00	55.1%
	Services Remaining	324,826.50	44.9%

Challenges to Implementation

Ensure that the data analysis and conclusions drawn from the proposed pilot project are designed to account for individual circumstances (hospitalization, provider changes, delayed billing etc.) that may impact how a TPM uses the services authorized in the PCP.

Remediation

The State will work with the case management system vendor and the US DOJ, SME, and other experts to create a report that will produce reliable results that may assist the State in creating additional strategies to successfully implement the requirements of the settlement agreement. **(Updated target completion date ~~December 1, 2024~~ June 1, 2025).**

Updated Progress Report:

A vendor-generated report provided the necessary data to analyze units used versus authorized. However, the vendor was unable to group the authorizations in a way that allowed for meaningful analysis. As a result, an HCBS Program Administrator manually organized over 10,000 rows of data to align with the service authorizations, ensuring all providers authorized to care for each recipient were accurately represented.

With the data now organized, we will collaborate with the research staff to analyze it and obtain accurate results for homemaker and personal care services.

The State has final data comparing the units used to the units authorized for residential habilitation and community support services. Since these two services are all-inclusive and provided by a single agency at a time, there was no need to group authorizations, simplifying the data analysis.

County Summary for T2016 Residential Habilitation				
		All Authorizations		**Unique**
County Claim	**Authorization Class**	**N**	**%**	**MMIS IDs**
Burleigh	Authorizations	44		8

	Authorized Services	4,010.00		
	Services Used	2,762.00	68.9%	
	Services Remaining	1,248.00	31.1%	
Cass	Authorizations	12		2
	Authorized Services	1,340.00		
	Services Used	937.00	69.9%	
	Services Remaining	403.00	30.1%	
Grand Forks	Authorizations	16		3
	Authorized Services	2,263.00		
	Services Used	1,873.00	82.8%	
	Services Remaining	390.00	17.2%	
McLean	Authorizations	14		1
	Authorized Services	94.00		
	Services Used	57.00	60.6%	
	Services Remaining	37.00	39.4%	
Mercer	Authorizations	13		1
	Authorized Services	413.00		
	Services Used	276.00	66.8%	
	Services Remaining	137.00	33.2%	
Morton	Authorizations	7		2
	Authorized Services	868.00		
	Services Used	729.00	84.0%	
	Services Remaining	139.00	16.0%	
Stutsman	Authorizations	1		1
	Authorized Services	155.00		
	Services Used	153.00	98.7%	
	Services Remaining	2.00	1.3%	
3 MMIS IDs had authorizations in two counties each. Those combinations were Cass/Stutsman, Burleigh/Morton, and McLean/Mercer.				

County Summary for S5126 Community Supports				
		All Authorizations		**Unique**
County Claim	**Authorization Class**	**N**	**%**	**MMIS IDs**
Burleigh	Authorizations	21		6
	Authorized Services	2,437.00		
	Services Used	1,828.00	75.0%	
	Services Remaining	609.00	25.0%	
Cass	Authorizations	25		7
	Authorized Services	2,056.00		
	Services Used	1,803.00	87.7%	
	Services Remaining	253.00	12.3%	
Grand Forks	Authorizations	3		1
	Authorized Services	186.00		

	Services Used	134.00	72.0%	
	Services Remaining	52.00	28.0%	
Morton	Authorizations	9		2
	Authorized Services	1,085.00		
	Services Used	778.00	71.7%	
	Services Remaining	307.00	28.3%	
Renville	Authorizations	6		2
	Authorized Services	923.00		
	Services Used	622.00	67.4%	
	Services Remaining	301.00	32.6%	
Stutsman	Authorizations	22		3
	Authorized Services	2,416.00		
	Services Used	2,102.00	87.0%	
	Services Remaining	314.00	13.0%	
Ward	Authorizations	27		6
	Authorized Services	3,283.00		
	Services Used	2,939.00	89.5%	
	Services Remaining	344.00	10.5%	
1 MMIS IDs had authorizations in two counties each. That combination was Burleigh/Morton.				

Updated Strategy 3. Implement an interface with the VAPS reporting system and the CIR reports in the current case management system based on a cost proposal and project timeline provided to the State. The interface would enhance collaboration and reporting of all types of critical incidents involving a TPM that were reported as a CIR, QSP complaint, or to VAPS. It would also help the State implement the HCBS Quality Measure set as required by CMS for states with MFP programs. **(Target completion date August 1, 2025)**

Progress Report:

The vendors have begun work on this project.

Updated Strategy 4. The State will continue to improve and revise its data collection efforts and will maintain a set of key performance indicators on the Department's website to illustrate the State's progress and challenges implementing the DOJ SA. **(Ongoing strategy)**

Key performance indicators include:

1. Referrals to HCBS
2. Average weighted HCBS case management caseloads.
3. Number of TPMs served in a skilled nursing facility (SNF).
4. Number of TPMs served in the community.
5. Number of TPMs diverted from a SNF.

6. Number of TPMs transitioned from a SNF.
7. Average annual cost of HCBS and SNF care
8. Average length of time from QSP application submission to enrollment.
9. QSP retention rate.
10. Number of agencies enrolled as providers.
11. Number of independent QSPs enrolled as providers.
12. Number of TPMs who are receiving 24/7 care and the number of QSPs authorized to support 24/7 care.
13. Number of QSPs by county; indicate tribal, rural and frontier.

Progress Report:

The KPI report is submitted to the SME every quarter and the most recent version is posted on the ND US DOJ SA website.

Section XIV. Performance Measure(s)

Number of service units authorized by territory.

- Link to Appendix D

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

Implementation Strategy

During the first year of the SA the SME drafted a Safety Assurance Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving diversions, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

Progress Report:

The State has implemented many of the strategies recommended in the SME Safety Assurance Plan. However, the plan has been removed from the Year 5 IP, and progress is no longer tracked in this format. Instead, the most up-to-date SME recommendations are available in the SME Compliance Report online.

Link to October 2024 SME Compliance Report

Updated Strategy 1. ND will use a portion of the Vulnerable Adult Protective Services Coronavirus Response and Relief Supplemental Appropriations Act of 2021 funds to implement a unified critical incident reporting process. The unified system will meet the requirements of the HCBS quality framework that must be adapted by states with an MFP

grant. All vulnerable adult protective services staff will have access to the critical incident reporting form in the web-based data collection system. Reports will be collected and automatically shared electronically to the case management system to be included in the critical incident reports. This will create a unified system for collection and sharing of critical incident reporting throughout Aging Services. This should allow for better coordination of services and data tracking. ND will continue to fund these efforts through the ARPA funding for Adult Protective Services. **(Updated target implementation date ~~February 1, 2024~~ September 30, 2025)**

Progress Report:

The State received procurement approval in December 2024 therefore the project is just beginning. A kickoff meeting was held in January 2025 and the work is underway.

Quality Improvement Practices (Section XVI, Subsections A & B, page 24)

Implementation Strategy

Updated Strategy 1. The State will continue to provide quarterly critical incident reporting training opportunities for QSPs. The trainings are advertised by sending emails to agency and individual QSPs and posting training dates on the QSP Hub website. The State will also utilize the help of the ND LTC Association to remind their members about reporting requirements and will provide individual training if certain QSPs show a pattern of submitting late reports.

Information about the training is included in the QSP handbooks and will be included in the QSP orientation that will be required as part of QSP enrollment starting January 1, 2024. Training will be provided through online modules and virtual training events. The training will focus on the State's data system and the State's processes for reporting, investigating, and remediating incidents involving the TPM. **(Ongoing strategy)**

Progress Report:

See Section XIII.B.Updated Implementation

Updated Strategy 2. Agency QSP enrollment standards require licensed agencies or entities employing non-family community providers to have a Quality Improvement (QI) program that identifies, addresses, and mitigates harm to TPMs they serve. This would include the development of an individualized safety plan. The QI Plan will be provided to the State upon enrollment and reenrollment as an agency QSP. The safety plan need not be developed by the provider unless it was not included in the PCP developed by the HCBS case manager and the TPM using the risk assessment in the State's case management system. **(Ongoing strategy)**

Challenges to Implementation

Some QSPs struggle to implement a QI program because they lack training and staff to create a robust program.

Remediation

The State has hired a nurse who will be responsible for providing technical assistance to QSP Agencies to help them implement robust QI programs. State staff review all QSP QI programs for compliance. If a QI program does not meet standards, the State will provide technical assistance and may recommend additional training or resources the QSP agency can use to reach compliance. Agency QSPs may also contact the QSP Hub for additional training and support.

Progress Report:

Agency QSPs are to follow the quality improvement standards outlined in the QSP handbook. Standards are to be met through the implementation of policies and procedures that identify, address, and mitigate harm to individuals being served under Home and Community Based Services. Audits are conducted and a thorough review of agency policies and procedures are completed.

There are currently 210 QSP agencies with 176 agencies that require a QI program subject to auditing. To date, 107 agencies have been audited and are considered to have met requirements based upon accreditation. The remaining 69 agencies will be audited in the future to determine if they meet the QI program requirements. Three (3) of the 107 agencies that have already been audited were found to be non-compliant and did not meet the QI program requirements. Many of the QSP agencies are small business who have not been in operation for a long time. Therefore, State works with these providers to develop a corrective action plan and follows up to ensure compliance.

Audits are conducted to determine if an agency is meeting the QI requirements and will continue to be an ongoing process as new agencies are enrolled to provide HCBS services.

Updated Strategy 3. National Core Indicators – Aging and Disabilities (NCI-AD) is a process that measures and tracks the State's performance and outcomes of HCBS provided to TPMs. The NCI-AD survey was completed by over 400 HCBS recipients in 2023. The State will review the results of the study and will collaborate with ADvancing States and the Human Services Research Institute (HSRI) to interpret the results. The State will include strategies to mitigate any identified quality issues, gaps in the service array, etc.in future versions of the IP. Quality performance reports will be made available on the DHHS website and shared at USDOJ stakeholder meetings. The State intends to complete the NCI-AD survey every two (2) years. **(Ongoing Strategy)**

Progress Report:

A link to the first NCI-AD report can be found below. The 2025 survey started January 3, 2024. Results will be included in future DOJ SA reports.

Link to U.S. Department of Justice Settlement Agreement | Health and Human Services North Dakota

Strategy 4. The State will continue to submit critical incident reports to the USDOJ and SME within seven (7) days of the incident as required in the SA. **(Ongoing strategy**)

Progress Report:

All critical incident reports (100%) were submitted to the US DOJ within the seven (7) day requirement.

The SA was updated on August 29, 2024 to streamline the types of incidents that must be sent to the DOJ. Based on this modified agreement the State now submits data within seven (7) days of the incident for: (**Ongoing strategy)**

- Deaths related to suspected abuse, neglect, exploitation, provider error, or resulting from unsafe or unsanitary conditions.
- Illnesses or injuries related to suspected abuse, neglect, exploitation, provider error, or resulting from unsafe or unsanitary conditions.
- Alleged instances of abuse, neglect, or exploitation.
- Changes in health or behavior that may jeopardize continued services.
- Serious medication errors; or,
- Any other critical incident that is required to be reported by state law or policy.

New Strategy 5. Aging Services nurse administrator is responsible to work with State staff to implement the HCBS Quality Measure Set as identified in SMD# 22-003 RE: Home and Community-Based Services Quality Measure Set (Link to Measuring and Improving Quality in Home and Community Based-Services/Medicaid). The HCBS Quality Measure Set is designed to assess quality and outcomes across a broad range of key areas for HCBS. The HCBS Quality Measure Set is also intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. CMS plans to incorporate use of the measure set into the reporting requirements for specific authorities and programs, including the Money Follows the Person (MFP) program, but has not given a specific date of when that will happen. The

State will begin the process of implementing these measures by providing a training for DHHS HCBS staff on the details of the measures and their intended use. **(Ongoing Strategy)**

Progress Report:

The implementation of the CMS quality measure set is an ongoing process, Heather Lindsley was hired October 10, 2023 and has completed a crosswalk of current processes and the new requirements. Changes to HCBS case management assessments and documentation to meet the CMS quality measure set were drafted during multiple workgroup sessions to ensure that efforts to implement required changes were done in collaboration and promote streamlined and efficient workflows. Process development is underway for the CMS quality measure set. HCBS case manager supervisors and HCBS program administrators have been educated on the CMS quality measure set requirements.

Training has completed with the Adult & Aging Services Division regarding the NCI-AD survey which is required in the HCBS quality measure set.

New Strategy 6. Update North Dakota Admin Code 75-03-23 to require Agency QSPs who have accepted an authorization to provide 24-hour supports to an eligible individual to give a 30-day written notice before they can involuntarily discharge the eligible individual from their care unless otherwise approved by the Department. This will increase the quality of 24-hour supports and help the providers to understand the commitment they are making when they agree to assist a TPM with this level of need. If a QSP does not provide a 30-day written notice it will be submitted as a complaint to Aging Services and it may lead to sanctions or termination of a QSPs status. (**Completed January 1, 2024)**

Progress Report:

This process is being added to policy:

QSP Required Notice for Involuntary Discharge 24-Hour Support Services

Under North Dakota Admin Code 75-03-23 Agency QSPs who have accepted an authorization to provide 24-hour supports to an eligible individual are required to give a 30-day written notice before they can involuntarily discharge the eligible individual from their care unless otherwise approved by the Department.

The 30-day written notice is required to increase the quality of 24-hour supports and help the providers to understand the commitment they are making when they agree to assist a TPM with this level of need.

If a QSP does not provide a 30-day written notice it will be submitted as a complaint to Aging Services and it may lead to sanctions or termination of a QSPs status.

Critical Incident Reporting (Section XVI, Subsection C, page 25)

Updated Implementation Strategy

Policy requires a remediation plan to be developed and implemented for each incident, except for death by natural causes. The State will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented**. (Ongoing strategy)**

Challenges to Implementation

QSPs do not always follow critical incident reporting requirements or fail to report critical incidents in a timely manner.

Updated Remediation

The DHHS Aging Services conducts critical incident reporting required trainings for QSPs. Training will be provided through online modules and virtual training events. The QSP handbook includes current reporting requirements and critical incident reporting requirements will be included in the QSP orientation that will be required to enroll or revalidate as a QSP. In addition, the State reminds providers of the reporting timeframes each time a CIR is not submitted on time. **(Orientation is now required as of January 1, 2024 and on-going)**

Progress Report:

See Section XVI. Performance Measures

Case Management Process and Risk Management (Section XVI, Subsection D, page 25)

Implementation Strategy

The State will use the case management system and the State's internal incident management system to proactively receive and respond to incidents and implement actions that reduce the risk of future incidents.

To assure the necessary safeguards are in place to protect the health, safety, and welfare of all TPMs receiving HCBS, all critical incidents as described in the SA must be reported and reviewed by the State. Any QSP who is with a TPM, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident in a timely manner.

Strategy 1. The case management system is used to receive and review all critical incidents. Providers and State staff have access to submit CIRs. Critical incident reports must be submitted and reviewed within one (1) business day. **(Ongoing strategy)**

Progress Report:

See Section XVI Performance Measures

Strategy 2. The DHHS Aging Services will continue to utilize a Critical Incident Reporting Team to review all critical incidents on a quarterly basis. The team reviews data to look for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the DHHS Aging Services Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services staff, LTC Ombudsmen, and the DHHS risk manager. **(Ongoing strategy)**

Progress Report:

Quarterly Critical Incident team meetings were held in January, April, July, and October of 2024. The top two (2) categories of incidents that have been reported to the DOJ include:

- Changes in health/behavior that may jeopardize services
- Medical emergency/ER visits

The state is currently working to offer training opportunities for QSP agencies regarding behavioral health and resiliency to assist in remedying the increase in behaviors jeopardizing services being reported by QSP's.

Updated Strategy 3. The State conducts a mortality review of all deaths, except for death by natural causes, of TPMs to determine whether the quality, scope, or number of services provided to the TPM were implicated in the death. The review is conducted by the quarterly critical incident report committee. The committee review consists of a review of the reason for the death, if there was an obituary/notice of death posted, if law enforcement was involved, and if there was an autopsy completed. Information gleaned from the review is used to identify and address gaps in the service array and inform future strategies for remediation. (**Ongoing strategy)**

Progress Report:

A mortality review is conducted at each quarterly meeting. Deaths are categorized by: natural causes, sudden/unexpected, other, and unknown. All deaths categorized under sudden/unexpected, other, and unknown are further reviewed and discussed by the Critical Incident Reporting team.

Notice of Amendments to USDOJ and SME (Section XVI, Subsection E, page 25)

Implementation Strategy

The State will submit written notice to the USDOJ and the SME when it intends to submit an amendment to its State-funded services, Medicaid State Plan, or Medicaid waiver

programs that are relevant to this SA, and provide assurances that the amendments, if adopted, will not hinder the State's compliance with this SA. **(Ongoing strategy)**

Progress Report:

- **Administrative Claiming & Expanded Provider Qualifications:** The State will now claim Medicaid funds for certain case management tasks and allow RNs with a bachelor's degree to provide case management. This aligns with other State waivers and maximizes federal funding.
- **Enhanced Case Management Services:** Agencies with expertise in culturally competent services can now provide Support Coordination, improving access, promoting health equity, and connecting participants with additional resources. State case managers will still oversee care plan development and monitoring.
- **Expanded Provider Access:** The amendment does not remove case management but broadens its definition to increase service availability. Care coordination will be provided by agency providers, including culturally and community-based organizations and Tribal entities. These updates improve HCBS access, ensure culturally appropriate care, and strengthen support for waiver participants.
- **Improve the Service Array:** Update tasks for extended personal care services to include providing a ride and escort to medical appointments because of communication or other impairments. This change was made because of the number of reasonable modifications we were making to allow this to be provided as part of the service a decision was made to change the policy.
- **Update Rate Methodology:** The rate methodology for cost-based rates under Fee for Service (FFS) waiver programs of Emergency response service and adult daycare changed from a rate based on providers submitted actual costs to be paid at the reasonable and customary rate. In addition, extended personal care, nurse educator, to be paid at maximum rate established for the service.

Complaint Process (Section XVI, Subsection F, page 25)

Implementation Strategy

Strategy 1. Continue to receive and timely address complaints by TPMs about the provision of community-based services. Complaints are tracked in the case management system. Complaints that involve an immediate threat to the health and safety of a TPM require an immediate response upon receipt. All other complaints require follow up within 14 calendar days. State staff collaborate with the Vulnerable Adult Protective Services unit to investigate complaints. The State will notify the USDOJ and the SME of all TPM complaints received as part of its biannual data reporting as required**. (Ongoing strategy)**

Strategy 2. The State publicizes its oversight of the provision of community-based services for TPMs and provides mechanisms for TPMs to file complaints by disseminating

information through various means including adding information to the DHHS website, HCBS application form, “HCBS Rights and Responsibilities” brochure, presentation materials, and public notices. **(Ongoing strategy)**

New Strategy 3. The State has seen an increase in the number of complaints that have been filed about the care provided by QSPs. This trend in reporting is indicative of the increased number of individuals receiving HCBS each year, the complexity of the care needed by TPMs, and awareness of the right to file a complaint. The State is monitoring the capacity of the Complaint Administrator to manage the increased reports and has made a request to the Executive leadership team for an additional FTE to be allocated to Aging Services in 2024.

Progress Report:

The request for an additional FTE has been made and we are awaiting approval. The State is also looking at systems that will assist the Complaint Administrator to audit billing more efficiently in situations where the complaint alleges poor care or inappropriate billing. **(Target completion date March 1, 2025)**

New Strategy 4. Include information in the required QSP enrollment orientation that describes the state and federal documentation and record keeping requirements for HCBS and the penalties for noncompliance. Information from the MFCU about their authority to investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities, board, and care facilities, and of Medicaid beneficiaries in noninstitutional or other settings will also be included. The purpose of the enrollment orientation is to help ensure that QSPs understand the responsibilities of providing state and federally funded services to TPMs and to deter individuals who may try to take advantage of the HCBS system for personal gain. **(Completed January 1, 2024 and ongoing strategy)**

Section XVI Performance Measure(s)

Number and percent of critical incident reports that were reported, by agency and facility providers, on time.

- Total average for 2024 73% reported timely (554/760).
    - Quarter 1 – 68% on time (164/242)
    - Quarter 2 – 75% on time (179/240)
    - Quarter 3 – 77% (157/204)
    - Quarter 4 – 73% (54/74)

Percent of Agency QSPs required to have a QI program in place that have one.

- 61% of the required QSPs agencies have been audited and have an

approved a QI program in place

Number of critical incident reports that have an associated complaint.

- There was a total of 25 complaints

Number of amendments reported.

- The HCBS waiver was amended once effective January 1, 2025.

Number of TPM complaints and outcomes

- There was a total of 127 complaints. Link to Appendix E

APPENDIX A

Appendix A is the Dashboard reports

APPENDIX B

2024 HCBS Case Manager Reviews/Audits Summary

Following are the standards for the Case Manager Quality Review Audits and the results of meeting those standards for year 2024. **Please note that the numbers in this report were valid as of the day it was created and may not match the dashboards or numbers in the body of the report.**

All HCBS CONSUMERS WILL HAVE AN OVERALL GENERAL AUDIT.

1. Standard:

   All Territories and all HCBS case managers will be reviewed annually.

   This goal has been met for year 2024 with all 8 Territories and all 70 Case Managers being audited. Standard:

   All individuals receiving HCBS services and not just the individuals chosen for the in-depth review, are reviewed to ensure that the Participant Assessment, Risk Assessment, and PersonCentered Plans are up to date for every client. This section was completed two separate times for all Case Managers in March and in September of 2024. All 3000 + consumers assigned to each case manager were reviewed to ensure that all were up to date on the Participant Assessment, Risk Assessment, and Person-Centered Plans. Supervisors followed up with the case managers for any Assessments, Risk Assessments and Care Plans that were not completed in the required time frame. These audits were completed on all individuals twice in 2024. Approximately 3000 clients between all funding sources were reviewed for the following:

   • Verifying that all HCBS Participant assessments are completed and up to date.

   • Verifying that all HCBS Risk Assessments are completed and up to date.

   • Verifying that all Person-Centered Plans are completed and up to date.

   • Verifying that all Case Manager case list in Therap is current and up to date.

This goal has been met for year 2024. All Territories were audited on all of the current open cases for the above information. In 2025, overall audits will be completed on all clients to ensure that a current Participant Assessment, Risk Assessment, and Person-Centered Plan audit are current and up to date for each consumer. These overall reviews will be completed in March and in September.

CONSUMER SPECIFIC IN-DEPTH CASE REVIEWS WILL BE COMPLETED ON EACH CASE MANAGER

2. Standard:

Client Specific in-depth case reviews will be completed on each Case Manager. 5% of each Territory's total number of open cases are pulled for the review.

Of the sample size of clients chosen to audit:

• 40 % will be Medicaid Waiver

• 30 % will be PCSP • 30 % will be SPED/ExSPED

• From the identified funding source categories, a random sample will be obtained using Random Number Generator: https://www.random.org/

• For each client that is chosen for the in-depth case audit, the following areas are reviewed:

• Review all Care Plans and all Authorizations for each funding source and each service that the client receives.

• Review the HCBS Participant Assessment in its entirety to assess whether all required information is in the assessment, and that the client meets functional criteria.

• Also, as part of the review of the Participant Assessment, review the Vision Tool, Quality Review, Caregiver Assessment if applicable, and the SPED fee section if applicable.

• Review the Financial assessment (SFN 820) for clients receiving services under SPED. • The Participant assessment is compared to each Care Plan and Authorizations to assess for consistent information, scoring, etc.

• Review the Person-Centered Plan for accuracy.

• Review the Risk Assessment for accuracy.

• Review if all required contacts, home visits, and assessments were completed.

• Review if the narratives /case notes contain the required information.

• Review the LOC Screening for all clients on Medicaid Waiver and MSP B or MSP C to assess whether the information is accurate and is consistent with the information and scoring in the assessment.

• Review if clients receiving services under SPED or Ex-SPED could meet LOC screening and instead receive services under Medicaid Waiver.

• Review if clients receiving services under SPED or Ex-SPED and receiving PCS, would be eligible for MA and receive the PCS under MSP.

• Review the Application for Services form for each client.

• Review the Rights and Responsibilities form for each client and if it is completed annually.

• Review if the translated R&R and Application forms were used when applicable.

• Review if the legal decision maker documentation is on file.

• Review if protocol for service Closings, Terminations, Reductions was followed for all funding sources.

• Review all Service Agreements and Worksheets for clients receiving a daily rate service and compare with the authorized tasks on the Authorization to assess for consistency.

• Review all QSP endorsements for clients receiving services who have a task authorized which requires a Global Endorsement or Client Specific Endorsement.

• Review all prior approvals and exceptions that are required from Program Administrators for each client.

• Review if a Settings Experience Interview was completed for individuals served in a foster home or ARC setting.

• Review if a lease agreement is in the consumer electronic file for individuals served in a foster home or ARC setting.

• Review if there is an IPP from the provider if applicable.

• Review if there is a NPOC from the provider if applicable.

This goal has been met for 2024. 147 individuals were chosen for in-depth case reviews in 2024. This section was met with the Program Administrator (Annette) completing the majority of the client specific audits (105) and the HCBS Supervisors completing 42 client specific audits each. 98 reviews were on individuals who meet the definition of TPMs (67%). A full audit report has been written for each of the 147 client specific audits.

3. Standard:

   40% of clients that were selected for the in-depth case reviews will also be seen for a home visit, unless prevented by unusual circumstances such as client illness, weather conditions, or lastminute client cancellations. A Client Interview report will be completed on each client who has been interviewed.

   Of the 147 consumers pulled for the in-depth review, 49 of those consumers were interviewed. This was 34 % of the consumers pulled for the in-depth review. The reason for this being lower than 40% is that this past year each Territory Supervisor only did 7 client interviews versus 8 due to the overall numbers being lower with Basic Care cases not being included any longer. Also, there were a few consumers who chose to not participate in a client interview or did not respond to a request for a home visit interview. A complete report has been written up on each client who was seen for an interview.

4. Standard:

   The State reviewer and HCBS Territory supervisors will meet with all Territory case managers to review results of every client specific audit and to spend time training and educating on better practices.

   This goal has been met for all 8 Territories for 2024. The Program Administrator met with each of the 8 Territory case managers in 2024 to review the findings and provide education on the corrections that needed to be made. For case managers who needed more assistance, one-on-one assistance was provided. Also, a significant amount of time was spent on offering recommendations in areas where there were not actual findings, but improvements could be made.

5. Standard:

   The Case Managers have 30 days to make all of the corrections and submit them to the reviewer.

   In 2024, this standard has been met, and all but 5 individual corrections have been submitted by the case managers. The 5 outstanding corrections have been submitted.

6. Standard:

   The reviewer has 30 days to review the corrections that the case manager has submitted and either close the audit or request further information.

   This standard has been met and all corrections submitted by the case managers were reviewed by the Program Administrator and HCBS Supervisors for accuracy. Some case managers needed to make further corrections but as of January 29, 2024, all corrections have been reviewed and accepted.

7. Standard:

   All information for each Territory and each consumer needs to be kept in an electronic file and needs to include the client audit report, the client interview report, and verification that all corrections have been completed.

   This standard has been met. Each Territory Audit folder contains a consumer file for each consumer audited, which includes the Case Management Audit Report, Client Interview Report, and all corrections.

8. **In addition to the overall audit on all 3000 + individuals we serve, and the 147 in-depth individual audits, there were 39 additional individuals who the DOJ and SME team reviewed and audited and provided input. Follow up was completed with the case managers and corrections made if needed.**

Summary of 2024 Case Reviews/Audits:

• The case managers do see their clients as required and many times more often depending on client needs. The minimum standard is not the norm and there is evidence of many client situations requiring monthly and even weekly contact/intervention.

• The clients who were interviewed voiced satisfaction residing in the community and with the services and their providers. Most all knew their case manager and knew who to contact if they had questions or concerns. They are overall happy with their services and with their case manager and grateful for the services assisting them in living in their own home.

• The Risk Assessment and Person-Centered Plan are being completed more thoroughly. Much of the focus of the audits was to provide education on how to improve the quality of the Risk Assessments and Person-Centered Plans; however, it is noted that many are done exceptionally well. There continues to be some overlap on the Participant Assessment, Person Centered Plan, and Risk Assessment, and continued work to streamline all information would be beneficial.

• Most of the Findings in the audits were related to:

- Not including all the required information and documentation in the ADL/IADL areas.
- Inconsistent information between the assessment and the PCP/Authorizations

- It is becoming more difficult for CM to complete all the documentation in Therap within the required time frames due to the increased demands of responding to consumer needs and the increased documentation and data entry that is required.
- Findings were also related to not completing the SPED financial document fully or an error in the fee assigned.
- Case Notes needed improvement with some of the case managers, but overall are done well.

• It is worth noting that in reviewing Case Managers documentation that they do work with community partners consistently, primarily Public Health, Home Health Care, OAA services, such as MOW and ND Assistive, Housing, Community Action, MA unit, mental health providers, etc. A significant part of their work did not involve HCBS services, but rather pulling in other community resources to assist to meet the individual's needs.

• Many clients required a monthly case management service.

• There is evidence of increasingly more crisis situations where the Case Manager may be the only case management support person involved in the case. To reduce duplication and manage referrals and caseloads the APS staff do not generally provide APS in situations that involve individuals who receive HCBS. Because there is an HCBS Case Manager involved they focus on the many other individuals who have no case management assistance. In addition, many years ago the HSZ stopped offering behavioral health case management to individuals who do not have acute mental health needs so the ability to have both a HCBS case manager and a Mental Health case manager was greatly reduced.

• There are increasing concerns with individuals we serve where substance abuse, violence, and/or illegal activity is present.

• There is evidence of frequently changing care plans, involving adding services or increasing services, clients discontinuing services or reducing services, and numerous QSP changes. Previously it was more common for a client to keep the same care plan for 6 months and this is no longer the case, with many more care plan changes in between the 6th month period. It is a rare occurrence that there are no changes in the 6 months timeframe or even 3-month time frame. This involves a significant amount of time for case managers in changing all forms, Pre-Auths, Care Plans, etc.

• There were very few instances of case managers missing a required contact. It is clear that clients are being seen and responded to when concerns arise.

• There is evidence that now more than ever, we are serving individuals with behavioral health needs with or without physical impairments and this requires a

significant amount of case management time without the additional support from other entities that used to be provided.

- The type of individuals being served, and the time needed for case management has increased due to client's complex physical and behavioral health needs.
- The ideology of Person-Centered Planning is embraced by case managers, and it is evident that case managers have been implementing Person Centered Planning in their work.
- Overall, the case managers do have a good understanding of HCBS Policies and Procedures, however due to numerous changes over the past years and due to the complexity of the programs, there is still confusion at times. The level of knowledge across the state depends some on the type of programs that are available, for instance not every area has an Extended Personal Care provider or Adult Residential Services. Also, we have many new case managers who are still learning and due to the complexity of programs, eligibility, and services, it will take them some time to be fully knowledgeable about HCBS. Emphasis has been on Supervisors gaining the knowledge on all policies, services, etc. and so that they can be the resource to their staff.
- There has been significant work done on balancing caseloads across the state and this has improved and is more stable; however, with the complexity of needs with the population we are now serving, number of referrals, caseloads are still too high in most areas, which results in case managers not being able to complete all the increased documentation requirements in the required time frame.
- Referrals are monitored monthly by the Program Administrator, and we have met all guidelines each month this past year, with timeframes of assigning a CM, the CM contacting consumers, and the assessments being completed within the set timeframe.
- A few Territories have tried specializing in having case managers being the referral specialists, working primarily with individuals served in adult residential care/ memory care settings, or working primarily with individuals transitioning from facility services to the community. Two areas had implemented referral specialists and one of these Territories has now gone back to having all CM take referrals as it was felt that it was more effective that way. Specialization is only possible in the larger areas and not possible in the rural settings where travel is too great to specialize.

APPENDIX C

MFP/TDPP Housing Facilitation Services:

Fill out applications for housing subsidies and for potential rental units.

Assist in locating needed documents for applications

Attend viewing of rental units including the walk-thru before signing the lease

Assure client understand the terms of the lease

Connect client to agencies who will be providing services.

Assuring modification and accommodations are in place when moving in and appropriate as needs changes.

Participate in person-centered planning, representing the housing wishes of the individuals being assisted with housing related needs.

Criteria:

- 60 days in a level of care facility (nursing facility, intermediate care facility, or hospital (NOT North Dakota State Hospital and NOT basic care); and
- On Medicaid or be Medicaid pending; or Medicaid expansion if applying for the TDPP program; and
- Moving from congregate living to a qualifying residence.

1915i Housing Support Services:

Assists participants with accessing and maintaining stable housing in the community.

Criteria:

- Serves children and adults;
- Currently enrolled in ND Medicaid or Medicaid Expansion; and
- Household income is at or below 150% of the Federal Poverty Level; and
- WHODAS score of 25 or above; and
- Resides in and will receive services in a setting meeting the federal home and community-based setting requirements; and
- Has one or more qualifying diagnosis.

ND Rent Help (ND Housing Stabilization):

Provide Household Engagement Coach who will provide training sessions to walk you through your least and “Letter of Commitment”, aiding in fostering a positive relationship with your housing provider and equipping you with the skills needed to become a successful renter.

Can provide assistance with past rent or utility rent or collections agency.

Can help with a security deposit.

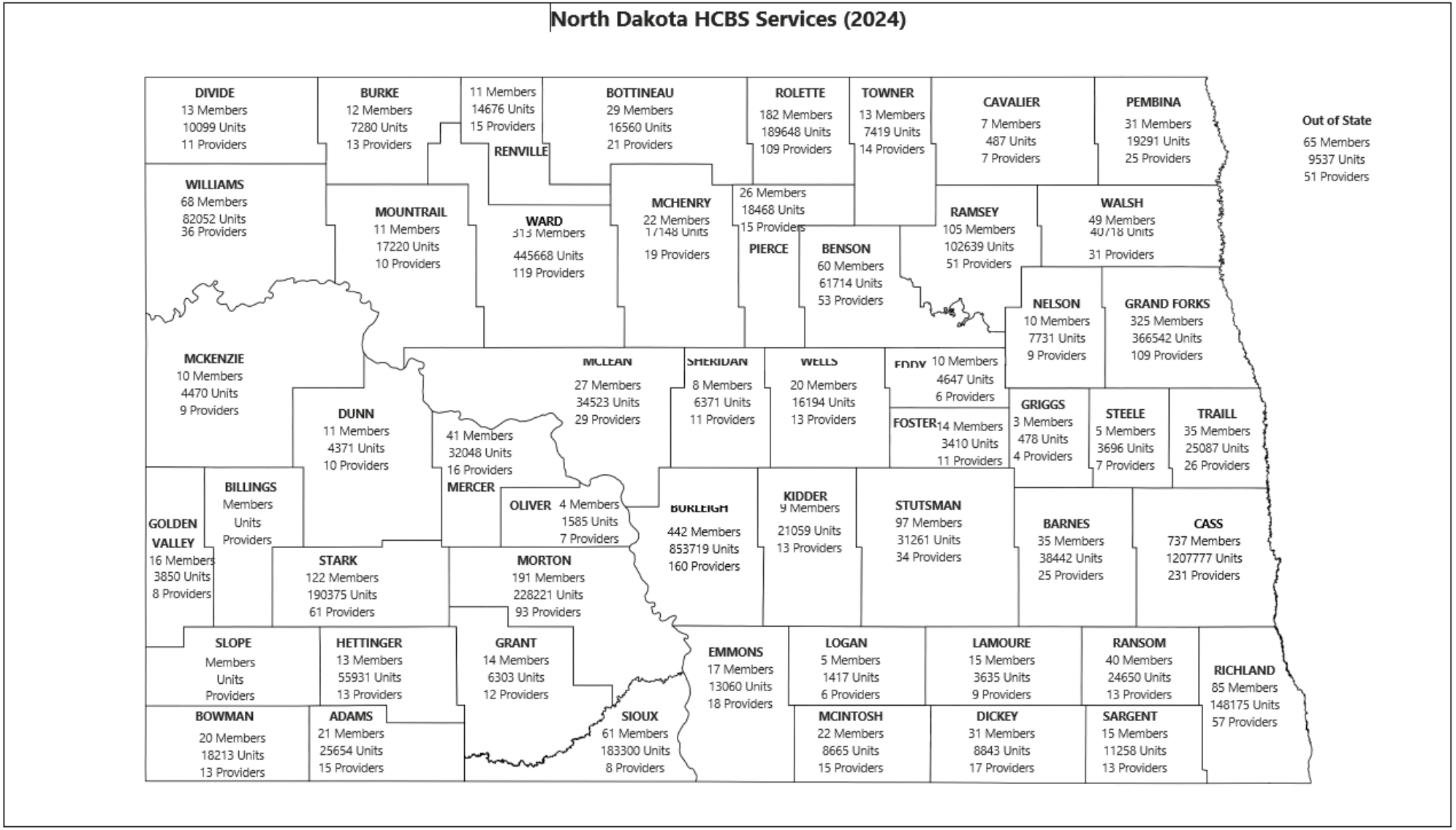
Can assist with up to 6 months of rent.

Can provide mediation services to resolve conflicts between renters and housing providers.

Criteria:

- Currently experiencing homelessness; or
- Received a written three-day notice to Quit or an eviction court date; and
- Required to meet with a coach; and
- You meet household income limits by county by household size – 30% of Area Median Income.

APPENDIX D


North Dakota HCBS Services (2024)
DIVIDE
13 Members
10099 Units
11 Providers
BURKE
12 Members
7280 Units
13 Providers
11 Members
14676 Units
15 Providers
RENVILLE
BOTTINEAU
29 Members
16560 Units
21 Providers
ROLETTE
182 Members
189648 Units
109 Providers
TOWNER
13 Members
7419 Units
14 Providers
CAVALIER
7 Members
487 Units
7 Providers
PEMBINA
31 Members
19291 Units
25 Providers
Out of State
65 Members
9537 Units
51 Providers
WILLIAMS
68 Members
82052 Units
36 Providers
MOUNTRAIL
11 Members
17220 Units
10 Providers
WARD
315 Members
445668 Units
119 Providers
MCHENRY
22 Members
17148 Units
19 Providers
26 Members
18468 Units
15 Providers
PIERCE
BENSON
60 Members
61714 Units
53 Providers
RAMSEY
105 Members
102639 Units
51 Providers
WALSH
49 Members
40718 Units
31 Providers
NELSON
10 Members
7731 Units
9 Providers
GRAND FORKS
325 Members
366542 Units
109 Providers
MCKENZIE
10 Members
4470 Units
9 Providers
DUNN
11 Members
4371 Units
10 Providers
MCLEAN
27 Members
34523 Units
29 Providers
SHERIDAN
8 Members
6371 Units
11 Providers
WELLS
20 Members
16194 Units
13 Providers
EDDY
10 Members
4647 Units
6 Providers
FOSTER
14 Members
3410 Units
11 Providers
GRIGGS
3 Members
478 Units
4 Providers
STEELE
5 Members
3696 Units
7 Providers
TRAILL
35 Members
25087 Units
26 Providers
41 Members
32048 Units
16 Providers
MERCER
OLIVER
4 Members
1585 Units
7 Providers
BILLINGS
Members
Units
Providers
GOLDEN VALLEY
16 Members
3850 Units
8 Providers
STARK
122 Members
190375 Units
61 Providers
MORTON
191 Members
228221 Units
93 Providers
BURLEIGH
442 Members
853719 Units
160 Providers
KIDDER
9 Members
21059 Units
13 Providers
STUTSMAN
97 Members
31261 Units
34 Providers
BARNES
35 Members
38442 Units
25 Providers
CASS
737 Members
1207777 Units
231 Providers
SLOPE
Members
Units
Providers
HETTINGER
13 Members
55931 Units
13 Providers
GRANT
14 Members
6303 Units
12 Providers
EMMONS
17 Members
13060 Units
18 Providers
LOGAN
5 Members
1417 Units
6 Providers
LAMOURE
15 Members
3635 Units
9 Providers
RANSOM
40 Members
24650 Units
13 Providers
RICHLAND
85 Members
148175 Units
57 Providers
BOWMAN
20 Members
18213 Units
13 Providers
ADAMS
21 Members
25654 Units
15 Providers
SIOUX
61 Members
183300 Units
8 Providers
MCINTOSH
22 Members
8665 Units
15 Providers
DICKEY
31 Members
8843 Units
17 Providers
SARGENT
15 Members
11258 Units
13 Providers

APPENDIX E

Complaint Type	Number of complaints by Type	Pending Outcome	Unsubstantiated	Substantiated	Remediation provided
Absenteeism	13	8	3	2	2 complaints of absenteeism were substantiated: 1 agency foster home was issued a correction order, 1 agency completed a remediation plan developed by Adult and Aging Services Section; 13 complaints of absenteeism are pending; however, the providers submitted a remediation plan to ensure adequate staffing moving forward.
Abuse/Neglect/Exploitation	1	0	1	0	Unsubstantiated
Breach of Confidentiality	2	1	0	1	1 complaint substantiated a breach of confidentiality, the agency ensured employees were retrained
Care unacceptable to the department	87	35	18	34	14 providers received complaints of unacceptable care that were substantiated: 2 providers were terminated, 6 providers completed a remediation plan developed by Adult and Aging Services Section, 6 providers provided a remediation plan that was accepted by Adult and Aging Services Section. 14 providers have complaints of unacceptable care pending an outcome. Issues surrounding poor care were immediately addressed.
Criminal History/Activity	2	0	0	2	Both agencies submitted an appropriate remediation plan, employee were terminated.
Inappropriate Billing	11	6	5	0	6 Pending Outcome
Other	3	2	1	0	Pending Outcome and Unsubstantiated
Poor Case Management	0	0	0	0	

QSP Damage Recipient Property	0	0	0	0	
QSP Disrespectful	3	2	0	1	Employee was terminated
QSP under the influence of Drugs/Alcohol	1	0	0	1	Employee was terminated
Self-Neglect	0	0	0	0	
Theft	4	2	2	0	2 Pending Outcome 2 Unsubstantiated
Total complaints associated with TPM	127	56	30	41	