North Dakota Settlement Agreement with the US Department of Justice

Report of the Subject Matter Expert

October 2024

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INTRODUCTION

In December 2020 the State of North Dakota entered into a Settlement Agreement with the United States Department of Justice (USDOJ) resolving complaints alleging that the State failed to administer long-term services and supports to people with physical disabilities in the Most Integrated Setting appropriate, in violation of the Americans with Disabilities Act. The Settlement Agreement required the development of Implementation Plans to identify benchmarks and timelines for meeting requirements, biannual data and progress reports by the State, and biannual reports from the Subject Matter Expert (SME).

This Report, the seventh biannual Compliance Report submitted by the Subject Matter Expert (SME), is for the recently concluded time period (December 13, 2023 – June 13, 2024).

The State of North Dakota has made significant progress in meeting both the spirit and the letter of the Settlement Agreement with the USDOJ that was initiated nearly four (4) years ago. While challenges remain that are yet to be fully navigated, success stories abound. The potential for further progress may depend on the Adult & Aging Section, its sister sections and divisions, contracted partners, service providers, the State's hospitals, and Skilled Nursing Facilities (SNFs) further building and sustaining productive partnerships. The State is aware of this and is moving forward.

The Subject Matter Expert and SME team have recently reviewed nearly 60 Person Centered Plans (PCPs) and, in September of 2024, along with USDOJ, interviewed nearly two (2) dozen Target Population Members (TPMs) during an onsite visit in North Dakota. While on site, additional interviews were conducted with all four (4) Centers for Independent Living (CILs) who assist in transitions from Skilled Nursing Facilities to home and community-based services (HCBS) for Target Population Members. Each CIL has a targeted area of the state for which they provide services. The SME team and USDOJ also met with the Settlement Agreement Coordinator and State Program Administrators who monitor and manage these activities. Many learnings were gleaned from these discussions that are further elucidated throughout this report.

There are many success stories that speak to the enhanced level of teamwork involved in supporting an unprecedented number of TPMs in North Dakota, with increasingly complex barriers, to navigate the transition process and/or remain in the most integrated setting of their choosing while receiving adequate and high quality services and supports.

For example, a TPM with multiple complex medical needs, when asked how his current home living situation could be improved indicated that "I have what I need." Another TPM who transitioned six (6) years ago indicated "I'm very happy to not be in a nursing home." Apparent in the many stories of success is the need to expand these opportunities to more facility-based TPMs, many of whom appear to have needs that can be met in a home or other community-based setting.

REPORT STRUCTURE

This report is structured in the following areas subsequent to this introduction:

- Person Centered Planning
- Transition Services
- Addressing Behavioral Needs of TPMs
- Qualified Service Providers (QSPs)
- Housing
- Cognitive Capacity/Guardianship
- Modifications to the Settlement Agreement
- Diversions
- Resources and Reporting, and
- The Year 5 Implementation Plan.

There are challenges in most of these areas, but progress continues to be made and the State is working to further develop successful strategies – and create new ones – to remove any systemic barriers that may exist to assist individuals in returning home (transitions) or remaining at home (diversions). The pages that follow seek to highlight the successes of North Dakota, identify continuing challenges, and offer suggestions for consideration to address those remaining.

RECOMMENDATIONS

Throughout the course of this report, the SME has included a number of recommendations for the State to consider as it moves forward in creating the Year 5 Implementation Plan (Year 5 of the Settlement Agreement begins on December 14, 2024) and strategies to continue forward movement of the work that has been accomplished and that which still remains. For ease to the reader, those offered recommendations throughout the remainder of the report have been gathered here as an overview. It is important, when looking at recommendations that the reader understands the context in which they are offered and the issue which they are intended to address. That additional information is found in the relevant sections of this report. Many of these recommendations are pertinent to multiple sections of the Settlement Agreement (such as QSP Capacity and Transitions) and are designed to address issues impacting multiple programs and entities.

Each of the recommendations relates to an area in which the State is considering options and is in discussions with the SME about implementation strategies.

1. Develop workgroups to address cross-entity challenges (e.g. the State and the CILs) that lead to inefficiencies and excess administrative burdens.
2. Develop enhanced collaboration among internal Department of Health and Human Services (DHHS) sections and divisions including Medical Services (Medicaid), Behavioral Health, Developmental Disability, and Adult & Aging Services.
3. Enhance managerial capacity and internal administrative infrastructure at Adult & Aging Services – in part to address coordination/oversight of contracted partners such as the QSP Resource Hub and the Centers for Independent Living.

4. Consider how to document and take more effective action through the complaints process or other means in response to facilities (such as SNFs and hospitals) that make unsafe and/or overly rapid discharges that place at-risk TPMs at further risk, thus jeopardizing successful transition to the community. Consider adding an additional position at the State to improve the ability to respond to and follow up on complaints.
5. Develop strategies to address the intermittent service needs of TPMs. Intermittent care is often needed in services such as Personal Care, Homemaker, and Non-medical Transportation.
6. Improve processes in place to obtain durable medical equipment with a goal of more efficient delivery of the appropriate equipment.
7. Add additional staff to the CILs to focus on enhancing post-transition support.
8. Consider efforts in specific areas of the state where incentives could be considered to expand and enhance services.
9. Individuals living with a Serious and Persistent Mental Illness or substance use disorder should have this noted in their Risk Assessment with a mitigation plan provided.
10. Offer training for QSPs and case managers in several topical areas of behavioral health, such as de-escalation of aggressive and assertive behaviors, well-being for caregivers, and trauma informed services, combined with good supervision about how to apply that training.
11. Prioritize the implementation of a peer support pilot project to assist in the mitigation of challenges related to assisting TPMs to return to the community more rapidly and remain in the community longer.
12. Determine how to provide assistance for TPMs who exhibit "acting out" and challenging behaviors that jeopardize services. Provide similar opportunities for caregivers.
13. The State has raised concerns about people who live in homes that have fallen into disrepair, bringing up safety concerns with limited resources available to assist. This may provide an opportunity for DHHS to work with the ND Housing Authorities to create a program to help address these needs.
14. Consider innovative QSP recruitment efforts in targeted areas (particularly those that are more isolated), including incentives, to increase the ability to serve TPMs.
15. Determine if certain needed medical procedures or interventions that currently delay transitions and keep TPMs in nursing facilities or hospitals could be carried out after an individual has transitioned into a community placement in order to avoid delaying the transition process.
16. It is suggested that USDOJ, the SME, the State, and other entities such as Protection and Advocacy and Legal Services, work together to clarify and provide guidance on issues associated with cognitive capacity, guardianship, and power of attorney.

PERSON CENTERED PLANNING

The Subject Matter Expert's approach to working with North Dakota on person-centered planning is twofold.

First, there is the matter of compliance with interim benchmarks noted in Section VIII.I.3 of the Settlement Agreement. The current interim benchmark is to provide person centered planning to an additional 650 Target Population Members by the end of Year 4 (December 2024) above the benchmark for Year 2. There was no Year 3 interim benchmark. North Dakota has met the benchmark of completing 650 additional Person Centered Plans (PCPs) with at least half for each of the subpopulations of TPMs (at-risk and facility based) prior to the end of Year 4.

Second, the SME review of person centered planning and Person Centered Plans is conducted from a technical assistance perspective as well as a compliance review that assures PCPs meet the requirements of the Settlement Agreement and the needs of TPMs. The SME team seeks to provide information about intended outcomes that go beyond adherence to required minimum criteria for PCPs. This feedback is aimed at further quality improvement, strengthening PCPs to better align with the needs of individual service recipients.

YEAR 4 REVIEWS

The SME team has reviewed 59 PCPs in this reporting period. Plans are reviewed from diverse geographical regions of the state and represent members of the target population residing in Skilled Nursing Facilities and those living in the community, diverted or transitioned. This includes review of a significant number of plans for people with medically complex needs that are living in the community. Of the PCPs reviewed, 54 were deemed to be compliant with Settlement Agreement requirements. The other five (5) are considered conditionally noncompliant.

Although these five (5) plans are responsive to many of the required elements, one primary element – risk identification and mitigation – is consistently under addressed or unaddressed. The SME acknowledges that risk identification has improved. Boxes are consistently checked that comprehensively identify risks. However, in these five (5) cases, safety plans tend to be incomplete relative to action steps to mitigate each of the primary risks identified. In some cases there is no plan. The SME has indicated that persons who have a known behavioral health condition should always have that identified in the Risk Assessment (see section "Addressing TPM Behavioral Health Needs" in this report.)

The compliance rate for the nearly five (5) dozen PCPs recently reviewed by the SME is 91.5% (54/59) as the State continues both its high compliance rate and its commitment to continuous quality improvement in its response to feedback from the SME.

TRENDS

There has been an increase in the number of individuals living with a developmental disability who are being served through the Medicaid Waiver in Adult & Aging Services. Some of those individuals are also living with complex medical needs. Individuals in North Dakota must choose a set of services and supports that are managed by different sections of DHHS – Developmental Disabilities or Adult & Aging Services HCBS. After receiving more information, some individuals with developmental disabilities have chosen to move to Adult and Aging Services administered HCBS to receive additional services as well as having access to a larger provider population.

The USDOJ has highlighted this issue and, as recently as early October, the Parties had a productive meeting to discuss this issue. Discussion included exploring ways to intervene and potentially divert individuals on the Developmental Disabilities Waiver with medically complex needs that are at-risk of nursing home placement. The State is conducting high level internal discussions aimed at aligning Year 5 Implementation Plan strategies, Settlement Agreement requirements, and operational logistics, while ensuring that the desires of TPMs are honored and supported in as optimal and intra-divisional a manner as possible.

REDESIGN

The State is currently working on a redesign to its PCP and Risk Assessment documentation. A new Centers for Medicare and Medicaid Services (CMS) rule – *Ensuring Access to Medicaid Services Final Rule* – was published in April 2024 (https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-final-rule-cms-2442-f). The new federal requirements are designed to improve access to care; quality of care, and health and quality of life outcomes; promote health equity for people receiving Medicaid-covered HCBS; and ensure safeguards are in place for individuals that receive HCBS through Fee For Service delivery systems (as happens in North Dakota). This new rule comes with additional reporting requirements for the State, with the need to begin gathering data in January 2025.

To better address these new requirements in addition to those already in place under HCBS and the Settlement Agreement, North Dakota is making further efforts to streamline how they are gathering and reporting information in efforts to reduce redundancies in their documentation expectations and system. It will also require that changes are made to the Therap software, which is the State's database for HCBS and other human service agencies.

TRANSITION SERVICES

NUMBERS OF TRANSITIONS

Section XI, Subsection B of the Settlement Agreement requires that, "Within 18 months of the Effective Date and thereafter, transitions will occur no later than 120 days after the member chooses to pursue transition to the Most Integrated Setting." For a number of valid reasons, compliance with this requirement has proved challenging. However, recent data reflects that there has been an increase from 61.8% in the previous reporting period to 69% in transitions that take place within 120 days of consent to transition in this reporting period (2024 Aging Services DOJ SA Dashboard December 13, 2023 – June 13, 2024). Seventy-five (75) individuals transitioned during the reporting period.

TPM TRANSITION REFERRALS COMPLETED SUMMARY

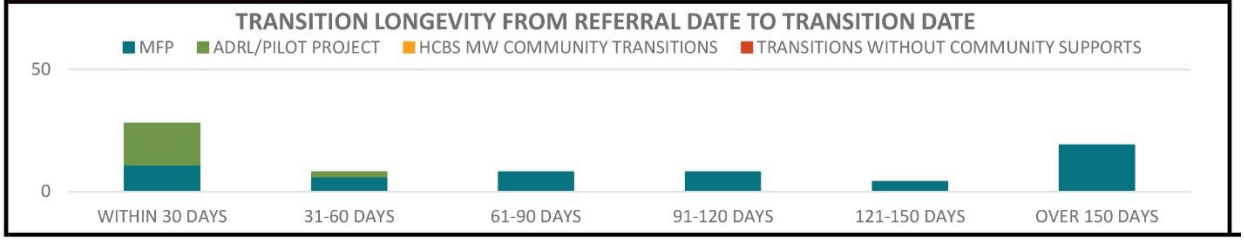
USDOJ SETTLEMENT YEAR (DECEMBER 14TH - DECEMBER 13TH)

TOTAL TPM TRANSITION REFERRALS THAT COMPLETED TRANSITION:			75		
TRANSITIONS	TOTAL	%	BY GRANT POPULATION		
			DD	ELDER	PD
MFP	56	75%	5	18	33
ADRL/PILOT PROJECT	19	25%	2	13	4
HCBS MEDICAID WAIVER COMMUNITY TRANSITION	0	0%	0	0	0
TRANSITIONS WITHOUT COMMUNITY SUPPORTS	0	0%	0	0	0

Additionally, the number of transitions taking longer than 150 days decreased from 37 in the last reporting period to 19 currently. Many of the TPMs that experience lengthier transitions have multiple complex barriers that require persistent navigation to overcome. As discussed in previous reports, the reasons for delayed transitions include but are not limited to, the predictable delays associated with the transition of TPMs with long-standing, complex medical and behavioral health issues, housing complexities including past felony or financial complications, lack of personal identification documents such as birth certificates or drivers licenses, and the desire to move only to a specific location where demand far outstrips supply (please see other sections of this report for additional information and activities being undertaken by the State to seek to improve these areas). This is coupled with communities challenged by provider capacity.

The State and its multiple partners are challenged to develop strategies and service system improvements to assist TPMs with multiple complex barriers to navigate through the transition process in an increasingly efficient manner. Recommendations for system improvements are included throughout this report and the State is developing and will present strategies in the Year 5 Implementation Plan that address these issues.

TRANSITION LONGEVITY	WITHIN 30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	121-150 DAYS	OVER 150 DAYS
MFP	11	6	8	8	4	19
ADRL/PILOT PROJECT	17	2	0	0	0	0
MW COMM TRANS	0	0	0	0	0	0
TRANS W/OUT SUPP	0	0	0	0	0	0



90+-DAY TRANSITION REPORT

The State maintains a list of individuals who are awaiting transition that have passed the 90-day mark of initial consent to transition and those who originally consented to transition who are no longer waiting, but have become "inactive." The State, SME, and USDOJ monitor this information closely to ensure that all steps are being taken so that these TPMs are able to transition to the community as efficiently as possible with appropriate services and supports in place to meet their needs.

Each month, the TPMs on the active list for at least 90 days (those who have consented to transition and remain in the process of doing so) are staffed through a multidisciplinary team focused on addressing and overcoming the barriers to transition. These meetings are convened by State administrative staff and involve all members of the individual's team (Transition Coordinator, Housing Facilitator, and HCBS Case Manager) to seek solutions to further facilitate the timeliest transition possible. Tasks are assigned during these meetings to address and resolve barriers to move the transition forward. There is a greater emphasis on this team planning and activity in the reporting period, resulting in a decreased number of individuals waiting for transition longer than 150 days and more having returned home.

The reasons individuals experience lengthy delays in transitioning into the community are varied and the complexities are, in many ways, unique to each individualized set of circumstances. Several issues require clarification including documenting the factors that determine a transition in status (both active to inactive and inactive to active) and providing clarity on how to "reactivate," ensuring that TPM choice is honored (even if that choice is to reside in a facility), resolving issues associated with guardianship and family not supporting a TPMs desire to transition, and making a determination of what services can be performed in the community (such as the use of weight loss medication or adjusting to the use of prosthetics) to mitigate unnecessary institutionalization and expand these opportunities to more target population members.

ADDITIONAL TRANSITON ACTIVITIES

The State does additional transition work to assist individuals to move to the community than those most noted in the Settlement Agreement through the Money Follows the Person (MFP) program. Since its beginning in 2020, the State has operated a Transition Diversion Pilot Project (TDPP) to assist people to return to the community through Aging and Disability Resource Link (ARDL) services. These individuals, while in a nursing facility or hospital, do not meet the criteria for MFP services due to length of stay in a facility but are TPMs. North Dakota determined to use *American Rescue Plan Act* funds to assist more TPMs to return to the community and engage with HCBS to avoid institutionalization. Additionally, some of these individuals that transitioned were in Basic Care settings in North Dakota. Basic Care facilities (what some might call assisted living in other states) are not eligible to participate in Medicare or Medicaid and therefore the clients are not TPMs as they do not meet criteria. The State chose to fund these transitions as well and also staff them through DHHS Case Management.

The program started small in 2020, with 17 transitions outside of the MFP program. The State reported that to date (September 2024) there have been 526 transitions through this initiative. It must be noted that in addition to the requirements of the Settlement Agreement, North Dakota has worked effectively to return more people to community settings through multiple funding sources.

CENTERS FOR INDEPENDENT LIVING (CILs)

North Dakota has four (4) CILs that provide services to individuals with disabilities of all ages. All CILs provide the following core services:

- independent living skills training,
- peer support,
- individual and systems advocacy,
- information and referral, and
- youth and institutional transition.

Since 2007, the CILs have worked with the State to provide transition services to individuals in institutions who wish to return to the community. In a recent interview, a soon to be transitioned TPM indicated that “the CIL has been pretty good to work with.” The State has contracted with the CILs to serve as the Transition Coordinators for TPMs. The SME team and USDOJ recently traveled the State and conducted key informant interviews with staff from each of the four (4) CILs. Feedback was gathered during these interviews that helped clarify areas of strength as well as opportunities for improvement.

The SME acknowledges that all parties, including the State’s case managers, options counselors, program managers, and transition coordinators have had an experience over the

> *“There are so many referrals now, the job has become boundary-less.”*

last four (4) years of "drinking from a firehose." A rash of rapid changes have produced pressure upon partnerships to work together toward solutions most in alignment with the desires of TPMs to live in the most independent manner possible in the most integrated setting of their choice.

The professional partnership between the CILs and the State continues to develop and evolve. Lines of communication are more open and CIL staff were effusive in their praise of the State's responsiveness and the quality of the technical assistance provided. There remain challenges and opportunities for improvement. One area in need of improvement is in the timely, detailed, and comprehensive documentation of risks and a safety plan - with action steps – to mitigate those risks that need to be taken for successful transitions and continued diversions.

Given the divergence of culture in communities served by the four (4) CILs, it makes sense that there would also be differences in management, operations, and communication style. These differences in style cannot be allowed to lead to inconsistent commitment to fully partnering with the State in the spirit of shared mission and teamwork. Adherence to meeting key Settlement Agreement requirements, let alone successfully navigating complex barriers to transition at-risk TPMs to the community in an optimally effective and efficient manner, will not occur absent commitment to continuous quality improvement.

It is for these reasons that the SME recommends additional resources in the form of an additional MFP Transition Services Specialist to work with the CILs. The current position has been highly effective in lending clinical and navigational skill to the transition process. Additionally, the SME is supportive of the scheduling of monthly meetings with both the directors and supervisors of the CILs. Technical assistance is an aspect of the State's relationship with the CILs, but contract oversight is as well. All parties need to be held accountable. Thorough documentation is a necessity, particularly in the area of health and safety plan development necessary to anticipate and mitigate comprehensively identified risks. This is in alignment with an additional recommendation to ensure that greater contract oversight be provided by Aging & Adult Services.

Several CILs have seen a large changeover of staff in the last three (3) years. One (1) is currently understaffed by two (2) positions and may actually require a third, and another has doubled its staff based on the workload presented by the State as it seeks to move as many individuals as possible to the community.

Transition Coordinators are a lynchpin in assisting individuals to return to the community. They must understand the nuances of institutions, work with teams to find necessary resources to assist people in getting home, and provide ongoing supports after a person has transitioned to assure they can remain at home. Of particular note from the CILs, it was indicated that one (1) of the most challenging tasks is in obtaining durable medical

equipment. While the equipment is generally approved, there is at times a lengthy wait to obtain some items. There is a need to improve the process in place to obtain such equipment, including when in the transition schedule this process begins. It is imperative that the determination and, ultimately, the delivery of the right assistive equipment be achieved in a consistently more efficient manner.

The CIL staff have commitments to three (3) separate programs that have three (3) separate funding streams. The three (3) programs are MFP transitions, Transition and Diversion Pilot Project (TDPP) transitions, and activities required by the State Plan for Independent Living through the Administration for Community Living (ACL). During onsite interviews with the CILs, the SME and USDOJ had the impression that, at times, some CIL staff felt overwhelmed with the sheer volume of work and documentation requirements associated with these programs. The scope of work for the CILs has significantly changed in the last four (4) years. The volume of work has escalated and the level of documentation required has grown. The existence of a Settlement Agreement has forever altered how the CILs operate and their relationship with the State. The State provides 100% of the funding for MFP Transition Coordinators and these staff must be fully dedicated to fulfilling contractual obligations to perform MFP Grant transition services, which are in direct alignment with compliance with Settlement Agreement requirements.

As mentioned, the CILs, in addition to MFP transitions, also assist in transitions for the TDPP. The CILs noted that it can be difficult to manage transitions that are more planned out as at times they receive notice of some transitions that happen within days, requiring them to pivot from other work and attend to the immediate situations. There have also been comments indicating that the CILs go into “rescue mode” to assist an individual who has been discharged (usually from a hospital) to the “street or shelter.” The State asks that Transition Coordinators working in either program respond as timely as possible to those rapid discharges. There is not, however, the expectation that the Transition Coordinator will respond on the same day if it is not practicable. As rescues have always been an aspect of CIL work it is important that CIL staff effectively manage rescues in such a way that does not deter from other priority activities.

The State indicated to the SME that Transition Coordinators are to be assigned to individuals served through the two (2) different transition programs. The TDPP program assists individuals who may not meet the requirements for MFP involvement (e.g. less than 60 days in an institutional setting) but who are ready to transition back to the community without further delay. It is our understanding that Transition Coordinators who are working through the MFP transition program should not also be working with individuals transitioning through TDPP. The SME is not sure that the division of transition coordination by program is taking place, gaining the impression through interviews that some Transition Coordinators are working across the two (2) programs.

An additional issue raised by staff at multiple CILs is the responsibility for attending to cases where the Medicaid application is pending. The expectation of the State is that Transition Coordinators will assist TPMs in resolving delays or problems in establishing Medicaid eligibility, such as helping to gather information to ensure proof of citizenship and the provision of necessary financial documents for the Medicaid application. The perspective of multiple CILs is that this is outside their scope, that they do not have enough staff to do so, and that this responsibility belongs elsewhere, "with the facility or the Medical Services Division." There appears to be a need for clarification on this issue. The State indicates that once an individual has applied for Medicaid, the CILs are asked to assume they will be eligible. If they are determined to be ineligible, the costs incurred in the completion of these activities would be absorbed through Transition and Diversion Pilot Project funding.

Feedback was prevalent that multi-disciplinary team staffings for the increasingly complex nature of cases is very helpful. While the CILs report they feel "less siloed" in their work and relationships are improved, there remain concerns from the State regarding issues such as comprehensive documentation, particularly when it comes to the development of health and safety plans, that it believes requires more attention. The State has, through the MFP program, a Transition Support Specialist who is working with individual CILs to ensure documentation is complete so that any issues can be more readily addressed and resolved.

"For us and our clients, the Settlement Agreement has been a game changer…there has been a real culture change…more people with disabilities than ever are living in the community."

Documentation requirements for MFP and other transitions (by funding) may vary from those required by the CIL for other work they conduct, but need to be addressed in more detail. The SME recommends a work group be convened to address the streamlining of reporting redundancies that exist. The work group needs to include staff from both the State and the CILs. The issue of staffing and training remain significant as well, as it does with Qualified Service Providers (QSPs), as noted later in this report.

POST-TRANSITION

CILs have identified that the work post-transition is greater than was expected. By requirement from MFP, the Transition Coordinator is to visit with the TPM at least monthly for the first year, more often if required, in addition to coordination with the HCBS Case Manager. At least one of the CILs has identified that these activities require more time than originally anticipated due to varying needs of TPMs. This can be a challenge with the number of transitions that the CILs are assisting in, which they note is much greater than prior to the Settlement Agreement.

The Dakota CIL (Bismarck) has implemented a new position (August 2024) of a post-transition support specialist. This person's responsibility is to complete the follow-up with TPMs after transition and ensure their needs are being met, staff are in place, etc. This should allow other Transition Coordinators to continue their work on assisting more people to return to the community. If this proves successful, it may provide a blueprint for other CILs as well as expansion in the Dakota CIL. The SME recommends that additional staff be added to CILs to focus on enhancing post-transition support.

ADDRESSING TPM BEHAVIORAL HEALTH NEEDS

Though not specifically referenced in the Settlement Agreement, it is clear that behavioral health issues have a direct and significant impact on several important elements related to the Agreement. Among the Settlement Agreement issues impacted are delayed transitions, re-institutionalization, housing, and QSP capacity. An element of QSP capacity is the training necessary to support a provider's ability to effectively respond to and intervene in behavioral health situations.

The SME team has been working with the State to identify potential solutions to assist case managers and QSPs in dealing with the day-to-day issues of serving people with physical disabilities who also have behavioral health conditions. In several calls between the SME team and State during this reporting period, the SME has provided resources to the State, including a list of Serious and Persistent Mental Illnesses (SPMIs), a resource guide for those private providers in North Dakota who accept clients whose insurance is Medicaid or operate on a sliding scale fee, and a list of rural psychiatry options.

The SME has indicated that individuals living with an SPMI or substance use disorder should have this noted in their Risk Assessment with a mitigation plan provided. Rapid changes can occur in individuals living with these conditions and a plan needs to be in place to assist a TPM in the event something should occur.

The State has indicated that there was a significant shift in how the Human Service Centers (HSCs) conducted business a number of years ago. This shift changed the relationship between them and Adult & Aging Services. The types of clients being supported by the HSCs decreased and the kinds of services being offered were reduced, leaving case managers with fewer resources to support HCBS clients with behavioral health conditions. Rather than addressing people with chronic mental health and substance use disorders, the HSCs have focused more on acute services.

The State has identified that case managers and QSPs need training on how to address the day-to-day issues faced with someone living with a chronic behavioral health disorder. Training in such topical areas as identifying and de-escalating agitated and aggressive behaviors, engagement skills and healing alliances, understanding identified risks and

mitigation strategies for the TPM, and the fundamentals of trauma informed care, combined with good supervision about applying that training, would go a long way to assisting in this area. There needs to be the ability for someone to go into the home and provide coaching to staff so they can retain what has been learned in training to better assist the client (and family). The SME can assist the State in locating trainings of this nature.

North Dakota has a 1915(i) Medicaid program that allows individuals with behavioral health conditions to access supportive home and community-based services. While some of these services mirror what is done by HCBS case managers, there is one particular area that may be of great value in addressing behavioral health: peer support. North Dakota has over 700 certified peer support workers – individuals with lived experience who are trained to help others living with similar challenges. There have been several conversations with Adult & Aging Services and the Behavioral Health Division about how to potentially use peer supports for TPMs, even if the peer does not have the lived experience of a physical disability. A plan is being mobilized to address peer supports in two arenas – those individuals who have remained on the transition list for lengthy periods of time and those who have transitioned that require extensive care to remain out of the institution.

There is additional work that needs to be done on logistics to begin using peer supports in these two areas, but planning appears to be underway. There are decisions to be made around financing, how to make use of 1915(i) resources, and how to begin to pilot peer support with TPMs to determine if it would be a useful added benefit. Case managers need additional information about peer support and the 1915(i) program. The SME team will continue to work with the State to address these issues.

It must be noted that there are also behavioral issues among TPMs that do not rise to the level of a behavioral health condition, but cause serious concerns in the delivery of services. There are some of those receiving services who lose QSPs (at times repeatedly) because of these behaviors that jeopardize services. This includes the use of illegal substances in the home when the QSP is there, the use of racial slurs, and aggression toward providers. Agencies are unwilling to put staff in situations affecting health and safety and many have lost staff because of these situations. What would seem useful in some of these instances is assistance for the TPM as well as for the caregiver in changing some of these behaviors. This assistance would focus on helping people become more aware of their own and others' attitudes, behaviors, and values, and learn how to interact with others in a respectful and tolerant way. How to accomplish that is more complex. It is felt that perhaps – if peer supports can be effectively deployed – that this may be one way to do so.

QUALIFIED SERVICE PROVIDERS (QSPs)

RECRUITMENT AND RETENTION

QSP Survey

The State, working through the QSP Resource Hub at the University of North Dakota (UND), distributes an annual survey to QSPs – individuals and agencies. The survey was streamlined in 2024, hoping by asking fewer questions the response rate, which has been good, would increase. Other questions were added focused on where the QSP lived and where they provided services. The survey provides useful information about things such as length of time the QSP has been working in the field, the type(s) of services the QSP offers, if the respondent is a family member, what training or support needs they have, and what would make it easier to become a QSP. It also asks about what would make it easier to remain as a QSP. The data could be further analyzed to, for example, assist in identifying issues of potential gaps in services in a geographic area or specific training requested in a region or by provider type. Initial data from the current report shows many people only having worked as a QSP for one (1) to two (2) years. The length of time is considerably higher for those who are family caregivers.

This year's survey was distributed in the summer and the data report became available in early October 2024. As was hoped, there was an increase in responses to the survey; 361 individual responses were received and 71 agencies gave feedback. The State will be meeting with the QSP Resource Hub to discuss results from the survey and developing potential strategies from information gained for the Year 5 Implementation Plan.

Enrollment Portal

The State launched a new enrollment portal that streamlines new provider enrollment and provider revalidation in January 2024. The portal continues to deliver a better turnaround time for enrollment in comparison to the previous paper system that could take weeks or months to get all the information gathered and processed. The DHHS Medical Services Division – the office that manages this process – indicates that enrollment has become much more efficient and is taking an average of eight (8) days to process after the provider has completed all information. The State reports that 22 new agency QSPs have enrolled this year.

As the portal is internal, the State has the ability to quickly run reports to obtain data. For example, they could use it to get more information on where the current QSP population is located and the array of services being offered. Using this information, like the information offered through the QSP survey, allows the State to target strategies in specific areas, if needed, or toward specific services. The State is to be commended for efficiently pivoting to a better solution after recognizing the flaws in the previous enrollment system and the adverse impact this was having on growing provider capacity.

Connect To Care

The State has also implemented Connect To Care, its new provider directory. Every QSP has an account in the database. The database is searchable and is publicly available, assisting TPMs in finding a QSP that can meet their needs. The database can be found at https://directcarecareers.com/north-dakota-workers-registry.

Basic geographic information was uploaded by the State to build this new database. Every provider has the ability to add information to their account including such topics as geographic areas they serve, services provided, and availability. QSPs need to "claim" their accounts to make use of them. Instructions were provided by the State on how to do this, but it is reported that only about one-third have done so. To combat this, the QSP Resource Hub is holding multiple events in communities across the state this fall to assist people in completing this activity.

Exit Survey

The State, also in conjunction with the QSP Resource Hub, prepared an "exit survey" designed to gather information on why people stop offering QSP services. The survey is sent on a monthly basis to those who have voluntarily stopped providing QSP services. It is hoped that this data will provide opportunities for the State to create strategies based on information given. There may be a way, also, to determine if the State could re-recruit these individuals to continue providing services, perhaps in a different capacity than what they did previously. This effort has begun only recently (September 2024) and the SME looks forward to what can be learned from these surveys and how new recruitment strategies could be developed.

TRAINING

The QSP Resource Hub offers many pre-recorded training videos related to administrative activities around being a QSP. They also offer QSP Monthly Update meetings where they can share information about changes in the program, answer questions live, and provide additional resources to QSPs who attend.

A priority for the State is developing additional training that addresses the quality of the services QSPs are providing. To be a QSP in North Dakota, the person must demonstrate competency in 21 standards that are central to caring for people with disabilities. The competency documentation must be updated each time the QSP revalidates their enrollment. The QSP must work with a licensed health care provider to prove they can meet these standards. Every QSP – whether an individual or agency provider staff – must meet competency standards to provide direct services. A challenge comes in ensuring that the standards are practiced correctly and consistently in the field.

QSP quality also needs to address such areas as professional behaviors of the QSP – being timely to work, properly completing all tasks assigned, treating TPMs with respect, etc. The

State wants to work with supervisors of agencies to offer more training in these areas so they can better manage their staff. Improving the quality of QSP services also means providing additional information on who the population of clients they are serving is. QSPs need training in dementia, behavioral health (mental health and substance use), traumatic brain injury, and responding to inappropriate and/or "unkind" behaviors from clients such as calling staff racial slurs or throwing things at them. None of these topics are covered in the competency standards required to be demonstrated, but they are the ones that create the most difficulty for the QSPs in doing their best to meet the needs of the TPMs.

CHALLENGES

We note two (2) areas of challenge in the recruitment and retention of providers in addition to the provision of additional training in an effort to reduce QSP turnover.

The State reports that it has become more difficult to find individuals who are willing to provide Personal Care and Homemaker services. These are often intermittent service requests – needing to happen a few times a day or a few times a week. Providers are seeking steadier schedules and blocks of time when they can provide services rather than managing a caseload of several people with similar needs who may not be geographically close together, increasing the difficulty of managing intermittent services as travel is not a reimbursable service under Medicaid for the provider.

The SME suggests that the State look at data it has and where there might be common areas this is occurring and consider creating a different plan with an agency provider that might mitigate some of these concerns. As an example (fictionalized), what if five (5) TPMs in Bismarck were in need of Personal Care, Homemaker, and Non-medical Transportation? All intermittent services. Could the State – if all the TPMs selected this agency provider as their choice – work with a single provider to assure that services were delivered as authorized to TPMs and incentivize the provider to do so? This probably is not a solution in many rural areas in North Dakota (where faith-based/church organizations play a role), but perhaps it could address part of the challenge of finding enough providers to offer these services in some locations.

The SME has suggested and the Agreement Coordinator has responded to suggestions on ways to incentivize providers for providing a block (such as two [2] hours) of intermittent services to multiple TPMs living in close proximity in hard to serve areas. Efforts are underway to see if there is a way to align provider needs with TPM desires when it comes to service delivery in the community.

A second challenge in the recruitment of QSPs is geography. The State has reported for some time that the most difficult areas to recruit providers are Jamestown and Dickinson. The reasons in these two regions are different.

In Jamestown, there are several opportunities for individuals who wish to work in the arena of human services, many of which are better compensated than serving as a QSP for HCBS. The North Dakota State Hospital is located in Jamestown as is the Anne Carlson Center. Additionally, the Region VI Human Service Center is also located in town and there are three (3) nursing facilities in the community. In 2022, the population of Jamestown is noted at 15,754. Of those, more than 450 are employed at the ND State Hospital and more than 600 are employed by the Anne Carlson Center. An unknown number are employed by the Human Service Center and the nursing facilities, but those numbers are sure to also be significant.

It is very difficult in a community of this size to build additional home and community-based services simply due to the potential workforce already being employed elsewhere. The State could consider a few options to improve this. It could look at the model of combining services for multiple TPMs with one (1) provider as noted above, if TPMs were in agreement with this provider being their choice. Could the State incentivize a provider in another region to expand their services? North Dakota has noted to the SME that there are providers in the Fargo area who are concerned because they are seeking more clients, do not have enough work, and only work in the public sector. Could they be incentivized to establish a satellite office in Jamestown, including relocating staff from Fargo to work in the Jamestown region? Or, perhaps, the providers that do work in Jamestown could receive additional resources to recruit staff from other areas to relocate and provide services.

The issue in Dickinson is different. The city has experienced a rapid growth in population as a result of a recent oil boom. Located in the western part of North Dakota, Dickinson is an energy and agriculturally-based community with a population (as of 2022) of just shy of 25,000. Dickinson has an 88 bed Skilled Nursing Facility in addition to multiple assisted living facilities. There are also numerous home health care agencies, some from very large providers in the state. It appears that many of these in home agencies have focused their work on the private pay population. Dickinson, like Jamestown, is also home to a regional Human Service Center.

The Dakota CIL is based in Bismarck, but had a staff person, until recently, in Dickinson. The staff person located in Dickinson for the Dakota CIL serves an eight (8) county area with a very small and scattered population. Finding QSP services in this area is very difficult. While the SME does not currently know the number of TPMs being served in that area (part of the authorization/utilization project underway), it must be noted that the population of those eight (8) counties, minus the 25,000 in Dickinson is less than 23,000 combined. Although the State provides a rural differential for travel to provide HCBS, it may not be sufficient. This is an area where the rate augmentation initiative could have a positive impact. The distance from Dickinson to Bowman, for example, in the southwestern corner of the state, is approximately 75 miles. With less than 3,000 people living in Bowman County, the likelihood of finding HCBS remains low without incentives to

encourage these services. Bowman County relies heavily on institutionalized services to meet the needs of TPMs. Again, the need to find a provider or more than one (1) in the area and combining services across multiple TPMs may assist in addressing this issue.

It is of note that even in harder to serve areas that struggle with quality provider capacity, there are success stories. A provider in one such area received praise from a TPM with multiple significant barriers that were navigated, including ensuring that the provider had sufficient back-up capacity; “Sometimes they (the caregiver) don’t show up and the boss comes right away.”

The State could look to target recruitment efforts in some of these more isolated areas, including targeted incentives, to increase the ability to serve TPMs. There are many individuals who don’t wish to leave an area where their family has been for decades yet are still in need of services.

HOUSING

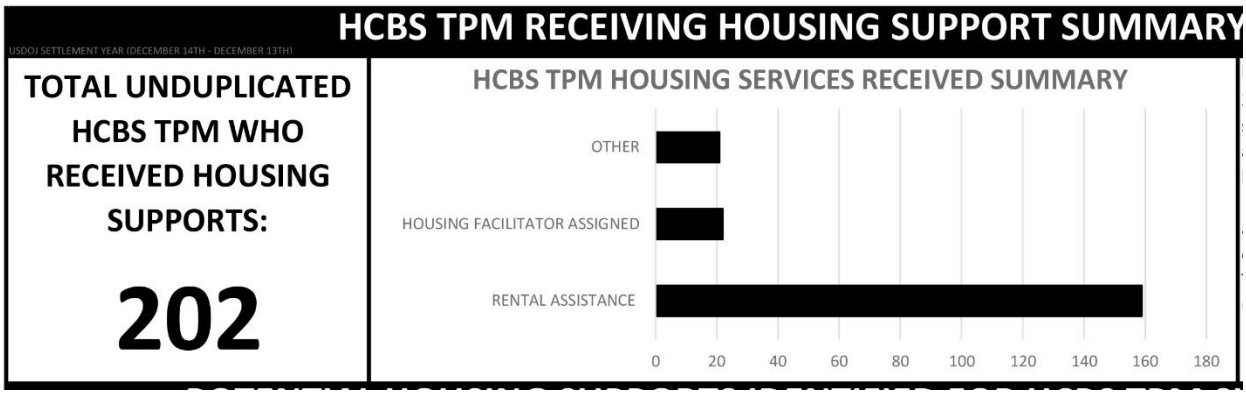
The State continues work on multiple fronts to both expand and coordinate resources relative to the completion of home modifications and working with developers and builders to ensure these happen more quickly. The State is proposing to increase the resources available in the Housing Incentive Fund as part of this process. The State is also working with a contractor from Minnesota called Next Day Access who offer a wide variety of mobility and accessibility products that they deliver and install to assist people in remaining in their homes. There have been some discussions about Next Day Access expanding into central North Dakota in the Bismarck area. If this happens, it would be of significant assistance to the State. In addition to making home modifications so that people can return to community living, there is also a desire to provide such services to those in the community so they can remain there longer. Typical modifications that are often needed include ramps, grab bars, patient lifts in homes and vehicles, and bathroom modifications. The State also continues involvement with North Dakota Assistive, which provides technology first initiatives.

The Centers for Medicare and Medicaid Services recently approved a plan where North Dakota can create a capital incentive fund – titled the Home Modification Capital Fund – to assist in having more opportunities to complete home modifications through the Medicaid Waiver. The State will create a pool of funds and contract with a provider to manage it. The fund will allow for contractors to be paid in installments for the work they complete in homes and will not require them to become a QSP to be able to do so. Once a project is complete, ND Assistive will bill Medicaid for the work provided, returning those funds, less an administrative fee, to the incentive fund to replenish it. Available funding will be $300,000 initially.

The State continues to report growing numbers of housing assistance provided to TPMs. In its most recent report (2024 Aging Services DOJ SA Dashboard December 13, 2023 – June 13, 2024), the State indicated that of those individuals transitioning to the community:

- 21 received home modification assistance,
- 33 received permanent supportive housing, and
- 30 received housing facilitation assistance.

The State also provides housing supports to people living in the community. As shown below, 202 TPMs received housing supports in the reporting period.



There are many aspects of assisting people to secure housing, going beyond a home that is accessible and affordable, though that remains of great significance. There are reasons specific to a person that can prevent them from easily obtaining housing. For example, they may have no identification and securing a birth certificate to get one is difficult. Others may have a felony history, making some landlords reluctant to rent to them. Still others may have a history of significant housing debt from not paying previous landlords or facilities.

The housing facilitators are the individuals that assist TPMs with these concerns. In onsite visits during early fall, the SME and DOJ heard that those facilitators do an excellent job. There is some concern about continuing to fund these positions in the future. Funding for these positions currently comes from *American Rescue Plan Act* funds, which end in 2025. To address this funding issue, the State will likely use MFP rebalancing funds and seek to administratively claim for Medicaid funds.

The State has raised concerns about people who live in homes that have fallen into disrepair. This brings up safety concerns and there are limited resources available. This may provide an opportunity for DHHS to work with the ND Housing Authority to create a program to help address these needs. There is a program though USDA Rural Development – Single Family Housing Repair Loans & Grants. Also known as the Section 504 Home Repair program, this provides loans to very-low-income homeowners to repair, improve, or modernize their homes or grants to elderly very-low-income homeowners to remove health

and safety hazards. Individuals must apply, qualify, and be approved for the loan, including having the ability to pay back the loan over a set period of time.

The State has started a Housing and Supportive Services Collaborative. Recent progress on the collaborative's initiatives includes connecting directly with the housing authorities throughout the state to participate in a Memorandum of Understanding (MOU) to designate TPMs as a "preferred" population when it comes to the distribution of housing vouchers. This is an important response to a recent federal prohibition on the "porting" of vouchers, a prohibition that adversely impacts state's that have smaller populations such as North Dakota. This group is pursuing several other goals including a new analysis of housing needs across the state, increasing opportunities through the 1915(i) State Plan Amendment, preparing information for the Legislature to educate them on the needs of their constituents, and creating a work plan to show how a state-funded rental assistance program is needed. One TPM lacking significant barriers and on the verge of transition recently interviewed indicated that "the housing voucher took a while…about four (4) months."

COGNITIVE CAPACITY/GUARDIANSHIP

During the SME's recent onsite interviews, it became apparent that a barrier to transition or more efficient transition is, at times, associated with the question of legal authority for decision-making. This involves a combination of factors including the determination of cognitive capacity, the determination of need for and timing of neuropsychological examinations, the role of guardianship, and the authority and reversibility of a Power of Attorney (POA).

> *"I'm stuck…my precious independence and freedom have been taken away from me."*

The SME and USDOJ recently interviewed a TPM who was refusing a facility mandated neuropsychological examination, indicating that she had a recent exam for which the facility has refused to give her the results. Additionally, a family member has a POA and she is wondering about having it revoked as she does not believe this family member has her best interests in mind. These two (2) issues appear to be preventing her return to the community. There is some concern that there are SNFs who may have the impression that proving competency is necessary to leave the nursing home. It would seem that unless definitively proved or there is significant evidence presented otherwise, that competency is to be presumed. The Settlement Agreement indicates that people can make their own decision about where they wish to live. An additional concern is that SNFs may see the existence of a Power of Attorney as indicating that the person cannot make their own decisions.

The existence of a Power of Attorney does not, of itself, indicate that the TPM lacks capacity to make their own decision, including the authority of the TPM to make a decision about transition. A POA also does not authorize the person to whom the POA has been assigned to make a decision in opposition to the TPM. There may be a lack of understanding of POAs by nursing facility staff that may be inadvertently and needlessly interfering with the transition process. A determination of whether or not this is accurate should be made and technical assistance provided as necessary.

An issue noted is that once the need for a neuropsychological examination has been determined necessary by a facility when an individual's capacity to make their own decisions is called into question, it is reported that it is not uncommon to experience a six (6) to 12 month delay in getting an appointment scheduled/completed. In some cases this is a primary cause of delay in the deinstitutionalization process. It would seem that the use of telehealth could be expanded to meet this need in the institution, home, or community to prevent unnecessary delays in transitioning. TPMs without a guardian must be able to make their own decisions regarding living in the most integrated setting of their choice that meets their needs.

If there is conflict between a guardian and the TPM about returning to the community, the State may want to consider finding a neutral third party to help determine what supports could be put in place for the TPM to move to the community even if the individual does have some cognitive limitations.

Another TPM interviewed in the September 2024 site visit, whose transition had been on hold, has recently been assigned a guardian who was in favor of this person's transition. It is anticipated that the guardian's opinion, in this case, will accelerate the process. In other cases, the guardian and/or family member is opposed to transition and this can complicate the process. It is not always clear if the TPM is being consulted about the desire to transition or if others are simply saying "no" and preventing transition to home and community.

This multitude of complex issues (including legal issues) require further analysis, clarification, and education. It seems that the State, SME, and USDOJ may be "at the tip of an iceberg" in beginning to recognize the extent to which these issues are significant barriers that require the implementation of new strategies. Options under consideration include elements of supported decision making and alternative dispute resolution. Additionally, there could be a greater focus on education for Transition Coordinators about guardianship and more education for guardians about HCBS and how people with limitations can still safely live in the community if they so desire. This will be a focus of joint efforts of the State, USDOJ, and the SME in the coming months and will be covered in more depth in future SME Compliance Reports.

MODIFICATIONS TO THE SETTLEMENT AGREEMENT

JULY 18, 2024

Two modifications were made to the Settlement Agreement in 2024. The first of these letters of modification removed the requirement for the State to complete a biannual report in June 2024, established the deadline for the Year 5 Implementation Plan to be completed (November 1, 2024), and set the date for the next biannual report in February 2025.

Additionally, several items that relate to the Year 5 Implementation Plan were outlined.

- The plan will include (a) a preliminary analysis comparing the units of home and community-based services authorized and the units of services utilized by TPMs and (b) strategies and metrics for identifying and resolving disparities in how services are delivered throughout the State. This is an important initiative that is built on a partnership between the University of North Dakota and the State, where staff are completing the analyses. This data is essential for determining if current strategies in the Implementation Plan are working and are worthy of further investment or whether changes in direction and the development of new strategies are called for. The intent is to provide evidence-based reasoning for such determinations.
- Expand the description of strategies to increase QSP capacity, including improving QSP recruitment, enrollment, and retention and explain how the State will determine whether each strategy has achieved its intended outcome(s).
- The plan will identify at least two (2) strategies for transitioning TPMs whose transitions have been pending for more than 100 days. Each strategy will identify the specific barrier(s) to transition that the strategy is designed to address, how the strategy will be implemented, any data that will be collected or analyzed as part of the strategy, and how the State will determine whether the strategy is successful.

AUGUST 29, 2024

The second letter addressed the reporting of Critical Incidents to USDOJ and the SME. The Settlement Agreement lists seven (7) broad categories of incidents that must be reported. During discussions between the Parties, it was determined that more narrowly defining these categories would provide the information pertinent to TPMs and decrease the amount of reporting that is required. As a result of these modifications, the reporting requirement has been streamlined and the workload for the State, USDOJ, and the SME has been lessened.

The new categories for reporting critical incidents to USDOJ and the SME are:

a) Deaths related to suspected abuse, neglect, exploitation, provider error, or resulting from unsafe or unsanitary conditions;

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

On a weekly basis, Critical Incident Reports (CIRs) are sent to the SME and USDOJ. The State and the SME continue to meet quarterly to address issue pertinent to individual CIRs and identify common trends. While the State continues to meet its timely reporting requirement, there are some agency QSPs that require continuing education relative to their reporting requirement, in part due to staff turnover and the need for re-training. A second frequent theme in the CIRs is the prevalence of behavioral health issues and other behaviors jeopardizing services. Clearly, access to better behavioral health resources and supports is needed, as is access to behavior intervention techniques.

AUTHORIZATION & UTILIZATION DATA PROJECT

QSP capacity has been and remains an issue for North Dakota. Many strategies are being implemented to increase the availability of providers across the State, along with recruitment and retention strategies as has been noted. As demand for services continue to show substantial growth year over year, it is important to determine a baseline for what services are authorized and what services are utilized. Doing so will allow the State to refine or expand programming in the future as the data drives decisions.

To that extent, DHHS, in concert with UND, has engaged in a project that reflects what services are being authorized, which of those services are being utilized, and any geographic gaps that might become apparent from this information. The data sets are starting at the macro level, looking at all HCBS services being authorized and delivered. From that information, analyses will be completed to see if there are any gaps related to specific services in specific regions. Further analysis, once this macro level data is available, will be required to determine why these gaps appear in the data. The State has expressed concerns about drawing premature conclusions absent understanding of individual circumstances. It is essential that the data be gathered and be available to locate trends that will require further analysis and take into consideration these individual situations.

This project is a significant undertaking. The Parties believe that this data can offer insights into the following areas now and can be replicated in the future to help the State address additional issues:

- Geographic trends in provider capacity,
- The shifting of supply and demand in various regions of the State, and
- Preparing for projected population changes for the next decades.

Data being analyzed is statewide and analyses will initially focus on four (4) services provided through the HCBS program: Personal Care, Homemaker, Residential Habilitation, and Community Supports. These services span the range of time a TPM might need support, from intermittent care to 24/7 services. UND indicates that it plans to have preliminary data to the State in October 2024. While not providing much time for in depth review due to other deadlines such as the Year 5 Implementation Plan required on November 1, 2024, it does allow the State to see if there is anything immediate that could be used to focus new strategies in the Year 5 Plan. The State will further incorporate additional elements of the analysis into its next Biannual Report in February 2025.

DIVERSIONS

The State has noted a significant increase in the number of HCBS clients over the course of the Settlement Agreement, reporting that the number of individuals being served is 40% higher than in 2020. Many of these cases involve individuals who are assisted with services that allow them to remain at home or in the community and are thus diverted from admission to nursing facilities. This increases the workload of the case managers, raising the average weighted caseloads (determined by the complexity of the case, distance to travel, etc.) to levels beyond what is optimal.

The number of cases opened continues to grow, documenting the increased desire by individuals to remain in their home and community as an alternative to institutional care. To address this, Adult & Aging Services requested from DHHS the addition of four (4) case managers prior to the next formal request to the Legislature in the 2025-2027 budget. The Department was able to meet this request.

In the State's most recent reporting period (2024 Aging Services DOJ SA Dashboard December 13, 2023 – June 13, 2024) a total of 179 additional TPMs were diverted from a Skilled Nursing Facility and remain in the community. The State should be commended for its continued efforts to support people in place.

USDOJ SETTLEMENT YEAR (DECEMBER 14TH - DECEMBER 13TH)	HCBS LONG TERM CARE (LTC) DIVERSIONS
UNDUPLICATED TOTAL NUMBER OF TPMs DIVERTED FROM A SKILLED NURSING FACILITY (SNF):	179
TOTAL MSP LEVEL B & C TPM DIVERSIONS:	56
TOTAL HCBS MED WAIVER TPM DIVERSIONS:	143
TOTAL SPED TPM DIVERSIONS:	48

RESOURCES & REPORTING

As was noted, an additional four (4) case managers were hired in this reporting period. The State hopes that an additional four (4) case managers can be approved early in 2025. The addition of direct care staff is necessary to address the significant growth in referrals and caseloads that are also growing in complexity. However, it is also important to recognize the need for the leadership, expertise, capacity, and infrastructure to manage these operations.

Currently, Adult & Aging Services is without a Deputy Director and a Vulnerable Adult Protective Services Director. Previously, these two (2) roles were shared by one (1) individual. There is also need for more clinical supervisory support. As other positions have grown, management capacity and administrative infrastructure must grow as well.

Reporting requirements have increased over the past four (4) years and will continue to do so with the new Access rule published by the Centers for Medicare and Medicaid Services. Adult & Aging Services, in addition to direct services provided, is also working on 24 special projects to improve programs. These include such things as the authorization and utilization project noted earlier, designing a pilot project to determine if peer support would be a useful addition to TPMs and how to launch that pilot, working with Economic Assistance and a vendor to create a report that will identify people who have submitted a pending application to Medicaid to confirm that they are TPMs who require options counseling, and Native American Stakeholder services, among many others. The State has completed multiple projects including the awarding of both provider transportation and QSP incentive grants in March 2024 and implemented the rate augmentation initiative. The addition of administrative staff to support this work is suggested.

The State is working on ways to streamline reporting. Part of that was noted in the Person Centered Planning section of this document, but there are other alterations that need to be addressed. The SME has encouraged the State and the CILs to share specific ideas for streamlining with the SME and USDOJ if there are areas that might affect reporting requirements for the Settlement Agreement.

YEAR 5 IMPLEMENTATION PLAN

The State is preparing the Year 5 Implementation Plan. It must be completed by November 1, 2024, for review by the SME and USDOJ. As has been noted, USDOJ is looking for additional strategies to address some of the most complex challenges continuing to face Adult & Aging Services (HCBS and Transition Services) as well as more detailed and in-depth information for the strategies that already exist and will continue in the plan. The State has been working to create “fact sheets” about what has been accomplished in the

first four (4) years to better inform the public. They are also gathering stories from TPMs who live successfully in the community – whether having transitioned or diverted – to inform the public about how HCBS can allow people to live at home. This information will be incorporated into future Implementation Plans and Biannual Reports.

CONCLUSION

The State of North Dakota started down the road of individual independence, informed choice, and access to home and community-based options before a Settlement Agreement was initiated nearly four (4) years ago. They had a vision and have been diligent in keeping to that vision and hard working in operationalizing it. The Settlement Agreement has spurred movement and progress along this path.

As with any lengthy endeavor worth embarking upon, the destination is not attained absent the continuing growth and strengthening of partnerships. Recommendations in this report focus on development on this front along with the human resources needed to manage the next steps on the journey, which include complex issues not easily or quickly resolved. Discussions regarding all of the complex issues happen regularly with the Parties and the SME. Many of the recommendations contained in this report align with those being considered for implementation in conjunction with strategies being developed by the State in its Year 5 Implementation Plan.