Implementation Plan

December 14, 2024 – December 13, 2025

North Dakota Department of Health and Human Services

Aging Services

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List of Acronyms

ADA – Americans with Disabilities Act
ADRL – Aging and Disability Resource Link
ARPA – American Rescue Plan Act of 2021
CAPABLE - Community Aging in Place, Advancing Better Living for Elders
CCBHC - Certified Community Behavioral Health Clinic
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR- Critical Incident Report
CQL – Council on Quality and Leadership
DD – Developmental Disabilities
DDPM – Developmental Disabilities Program Manager
DHHS – Department of Health and Human Services
DME – Durable Medical Equipment
EPCS – Extended Personal Care Services
EVV – Electronic Visit Verification
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
HUD – Housing and Urban Development
IP – Implementation Plan
LTSS OC – Long Term Services and Supports Options Counseling
LTC TCM - Long Term Care Targeted Case Management
MFCU – Medicaid Fraud Control Unit
MFP – Money Follows the Person
MFP-TI – Money Follows the Person-Tribal Initiative
MMIS – Medicaid Management Information System
MOU - Memorandum of Understanding
MSP-PC – Medicaid State Plan-Personal Care Services
NCI – National Core Indicators
NCI-AD – National Core Indicators – Aging and Disability
ND – North Dakota
NDAC – North Dakota Administrative Code
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
SA – Settlement Agreement
SME – Subject Matter Expert
SNF – Skilled Nursing Facility

SPED – Service Payments to the Elderly and Disabled
TBI - Traumatic Brain Injury
TDPP – Transition and Diversion Services Pilot Program
TPM – Target Population Member
UND – University of North Dakota
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

About the Settlement Agreement (SA)

On December 14, 2020, the State of North Dakota (State) entered into an eight (8)-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 addresses a variety of concerns that were brought forward by Target Population Members (TPMs). The concerns included the following:

- Unnecessary segregation of individuals with physical disability in Skilled Nursing Facilities (SNFs) who would rather be served in the community,
- Imbalance of funds for services delivered in Skilled Nursing Facilities versus community-based services, and
- Lack of awareness about existing transition services and other available tools people can utilize to access in-community supports.

As defined in Section IV of the SA, for purposes of the SA, a **TPM** is:

- an individual with a physical disability,
- over the age of 21,
- who is eligible or likely to become eligible to receive Medicaid long-term services and supports, and;
- likely to require such services for at least 90 days.

The strategies developed to meet the requirements of the SA will have long-lasting benefits for current and future TPMs who want to live and receive services at home and enjoy the benefits of living in a non-institutional setting. The work to be accomplished as per the SA will:

- Expand awareness of and access to community-based care,
- Allow individuals to make an informed choice about how and where they want to live and receive necessary services, and
- Build upon legislative investments and a shared goal to improve services to North Dakotans.

Implementation Plan Timeline and Process

This updated Implementation Plan (IP) includes the strategies that will continue to be implemented in Year 5 of the SA, as well as new strategies that were designed based on lessons learned and data from the first four (4) years of SA implementation.

Previous strategies that are completed or were not effective were removed and will be reported on in the Year 4 annual DOJ SA report.

The **Year 5** Implementation Plan pertains to a specific timeframe, **(December 14, 2024, through December 13, 2025)** of the Settlement Agreement. Some of the strategies and initiatives in this proposal are contingent on legislative approval and appropriation to fully implement. The State submitted a list of new initiatives and services for potential inclusion in the Department of Health and Human Services (DHHS) executive budget request. The Legislature will next convene in January 2025.

The document contains hyperlinks to help the reader navigate between the requirements of the SA and the strategies designed to meet those requirements in the IP.

The strategies under each section of the IP provide the details on how the State continues to meet the requirements of the SA during Year 5 of implementation. New or updated strategies are marked as such to aid the reader's review. The IP and strategies within the plan may be revised as necessary to meet the SA requirements.

Sections VI and XVII of the SA outline timelines that apply to the IP and subsequent updates.

Plan	Submitted By	Approved By*	Settlement Agreement Year	Time Period Covered
IP	May 25, 2021	Sept. 22, 2021	Years 1 -2	Dec. 14, 2020 – Dec. 13, 2022
IPr1 **	August 29, 2022	October 14, 2022	Year 3	Dec. 14, 2022 – Dec. 13, 2023
IPr2	November 1, 2023	December 13, 2023	Year 4	Dec. 14, 2023 – Dec. 13, 2024
IPr3***	November 1, 2024	December 13, 2024	Year 5	Dec. 14, 2024 – Dec. 13, 2025
IPr4	June 14, 2025	Aug. 15, 2025	Year 6	Dec. 14, 2025 – Dec. 13, 2026
IPr5	June 14, 2025	Aug. 15, 2026	Year 7	Dec. 14, 2026 – Dec. 13, 2027
IPr6	June 14, 2026	Aug. 15, 2027	Year 8	Dec. 14, 2027 – Dec. 13, 2028

Period of Substantial compliance: Dec. 14, 2028 – Dec. 13, 2029

Termination of SA if Substantial Compliance by Dec. 14, 2029 is achieved.

**The noted approval dates set in the future are estimated based on timelines suggested by the processes that are described in the SA.*

***Implementation Plan Revision (IPr).*

**** The State agreed to complete the Year 5 IP by November 1, 2024.*

The State will report on its progress in achieving the overall objectives of the SA, including updated progress on performance measures and SA benchmarks on a semiannual basis throughout the term of the SA.

The IP and all related reports will be made available to the public via the State's DOJ website: https://www.hhs.nd.gov/adults-and-aging/us-department-justice-settlement-agreement.

Our Vision: Realigning Systems of Care

North Dakota (ND) is actively working to transform the Home and Community-Based Services (HCBS) experience for TPMs, making sure it is streamlined, effective, culturally informed, and a viable alternative to institutional living.

The overarching vision that guides the State's efforts under the SA is to take actions that support the ability of TPMs to make an informed choice about where they want to live and how they want to receive needed services and supports.

The IP outlines dozens of strategies that, when taken together, is effectively changing the systems of care in ND, which will ultimately transform a TPM's ability to choose to live in an integrated community setting.

For this vision to be realized, ND needs to transform people's ability to access HCBS and housing supports and to effectuate necessary reforms in the hospital discharge and long-term care delivery systems in the State.

The strategies contained in the Year 5 IP continue to 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 informed choice.
- Widen the array of services available, including more robust housing supports.
- Strengthen interdisciplinary connections between professionals who work in behavioral health, developmental disability, 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.

- Improve the provider experience by continuing to update and improve technology solutions to assist with enrollment, provider access, documentation, billing, and claims payment.

A Review of IP Themes

The SA is structured in 18 sections. Sections I – VI and XVII-XVIII outline the overall parameters of the SA. Sections VII – XVI each outline an element of focus, which are intended to support the State's overall responsibility, per the SA, to serve individuals in the most integrated setting appropriate.

The State's IP is designed to follow the same "section" format as used in the SA. Key themes from each section are summarized below.

1. **Case management** is a core service that helps connect TPMs to the information and resources they need at a moment of a critical life decision. The availability of competent, person-centered case management that is built on a foundation of thorough and timely assessment is a critical component of any high-functioning HCBS system. *[Section VII of SA]*

2. **Person Centered Plans (PCPs)** need to be at the heart of the State's HCBS system. The strategies in the IP are intended to solidify the principles and practices of PCP development as a foundational element of the State's delivery of HCBS, both through training and the establishment of new processes that support in-reach as a critical element of connection. *[Section VIII of SA]*

3. To make non-institutional housing options possible, TPMs must have access to **community-based services** when and where they need them. The State used work groups to improve service delivery and reasonable modification processes, develop and deliver targeted training, and access to capacity-building resources and supports for service providers. *[Section IX of SA]*

4. Having access to information at the right time requires both the State and its private health-care partners to modify processes and practices related to screenings and Level of Care assessments. The IP focuses on evaluating and modifying policy as needed and on establishing a functioning **LTSS Options Counseling** referral process that can effectively identify TPMs and provide them with both information and a PCP to facilitate their informed choice. *[Section X of SA]*

5. Facilitating **transitions** from a SNF to community living requires coordination of resources and access to both housing and services in the community where a person is going to live. The IP builds capacity across systems to expand the

number of successful transitions that occur across North Dakota. *[Section XI of SA]*

6. Permanent supported **housing** (PSH) is the broad term used to describe community-based housing alternatives to an institutional setting. PSH must be integrated, affordable, and accessible as per a TPM's needs. Additionally, the TPM must be able to access the long-term services and supports the TPM needs to maintain independence in the community setting. The State will work with partners to broaden access to supports that create PSH in communities across North Dakota, including rental assistance, transition supports, resources to help modify living environments, and general facilitation of TPMs' needs related to identifying suitable housing. *[Section XII and XIII of SA]*

7. In North Dakota, HCBS are delivered primarily by private sector **providers**, both nonprofit and for-profit. Building private sector **capacity** to deliver services will require policy changes, incentives, coaching, and support. *[Section XIII of SA]*

8. Making connections at the right time and with the right resources is essential to enabling informed choice. Conducting effective **in-reach** and **outreach**, building capacity to serve TPMs, empowering peer and **natural supports**, and aligning screening and referral processes to support an individual PCP requires policy modifications, changes in process and practice, and training. *[Section XIV of SA]*

9. The State must be able to measure the impact of the changes it is making across systems by understanding the impact of work that happens within and between systems. The intentional development of cross-system approaches to **data collection** and analyses that are outlined in the IP will help assure continued attention to benchmarks, key performance indicators, and other performance measures. *[Section XV of SA]*

10. Defining and understanding indicators of **quality** in how services are delivered and how systems operate will require the State to examine performance measures that allow for direct assessment. *[Section XVI of SA]*

Updates to the Settlement Agreement

On **July 18, 2024** the SA was updated by the parties to remove the requirement for the State to submit the June 2024 semi-annual report. It also set a November 1, 2024 submission date for the Year 5 IP and February 1, 2025 deadline for submitting the Year 4 annual report. It also established timelines for the USDOJ and the State to have strategy meetings regarding the Year 5 IP and required the following items to be included in the IP.

The Year 5 IP submitted on November 1, 2024 will require:

1. Preliminary analysis comparing the units of HCBS authorized, and the units of services utilized by TPMs and strategies and metrics for identifying and resolving disparities in how services are delivered throughout the State.

2. State developed strategies for increasing Qualified Service Provider (QSP) capacity, including strategies for improving QSP recruitment, enrollment, and retention. In the IP, the State will expand its description of these strategies to explain how the State will determine whether each strategy has achieved its intended outcome(s) and outline the State's plan for collecting and analyzing data to support and evaluate each strategy.

3. Identify at least two (2) strategies for transitioning TPMs whose transitions have been pending for more than 100 days. See SA Section XI.B. Each strategy will identify the specific barrier(s) to transition that the strategy is designed to address, how the State will implement the strategy, any data that will be collected or analyzed as part of the strategy, and how the State will determine whether the strategy successfully results in TPMs transitioning from a SNF to the community.

4. The State will consult with the United States and the Expert as it prepares the Year 5 IP, and the State's Year 5 IP must be approved by the United States and the Expert.

The biannual report due February 1, 2025 will require:

1. The State to report the results of the preliminary analysis comparing the units of HCBS authorized and the units of services utilized by TPMs.

2. The strategies in the Year 4 IP related to transition planning, transitions from nursing facilities to community-based settings, and QSP capacity-building, to detail the effectiveness of each strategy and outline the information, metrics, or data used to determine effectiveness. The State will describe challenges and opportunities associated with each strategy. Based on these analyses, the State will describe any changes to these strategies for Year 5.

On **August 29, 2024** the Settlement Agreement was updated again with agreement from both parties to reduce the burden of submitting Critical Incident Reports (CIRs) to the USDOJ. The State will no longer be required to submit incident reports that involve deaths from natural causes that do not involve suspected abuse, neglect, provider error, or other safety concerns.

The following incidents will trigger reporting to the Agreement Coordinator, United States, and Subject Matter Expert (SME) within seven (7) days of the incident:

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.

The recent updates to the SA require the State to provide more detailed strategies to enhance the recruitment, enrollment, and retention of QSPs and to address barriers to transitioning individuals from Skilled Nursing Facilities (SNFs). The Year 5 IP reflects these requirements and outlines several strategies aimed at addressing these issues. These strategies are informed by data from the 2024 Agency and Individual QSP Survey (Link to QSP Survey), QSP Enrollment Portal reports, and the NCI-AD North Dakota Report (Link to report). Further details on the data and its impact on the Year 5 IP are provided below.

QSP Recruitment, Enrollment, and Retention

Summary of findings from the 2024 individual QSP survey. (28% response rate)

- **Close Personal Relationship**: 69% of individual QSPs had a close personal relationship with the person they serve that started before they became a QSP.
- **Demographics**: Most QSPs are middle aged women, with the largest group aged 55-64, followed by those 65 and older.
- **Education**: Most have completed high school and some college but did not earn a degree.
- **Employment**: For most, being a QSP is their only job. Those who work a second job typically work 20-29 hours, with some working 40-49 hours.
- **Experience**: 29% have provided care for 1-3 years, 23% for less than a year, and 27% for over ten (10) years.
- **Clients**: Most care for one (1) person, with a smaller group caring for 2-3 people. Few have private pay clients.
- **Hours**: Among agency employees 27% work 40-49 hours per week and 18% work 30-39 hours per week. They are also providing all the types of services they are enrolled to provide.
- **Job Influences**: Flexible schedules, simple paperwork, and pay are key factors in becoming and remaining a QSP. Others said assistance with billing, and streamlined certification were also important. Benefits, opportunity for

advancement, and continuing education and training opportunities were not influential in them staying a QSP.

- **Training Needs**. Most did not seek skill training opportunities, but those who do want training on specific diseases and medical conditions.
- **Referrals**: 46% do not want more people to be aware of their availability, while 28% want more referrals and help marketing.
- **Job Satisfaction**: 88% say their relationship with the person they support is the most satisfying thing about their work, followed by enjoying this type of work and having a flexible schedule.
- **Challenges**: Paperwork, billing, taxes and pay rates are the most challenging.
- **Motivation**: The primary motivation to become a QSP was a loved one needing care, followed by a passion for working with people.

Summary of finding from 2024 QSP Agency Survey. (37% response rate)

Agency Size: 67% of QSP agencies employ nine (9) or fewer people. 25% of agencies employ between 10-29 employees. Only four (4) agencies employ more than 60 people.

Employee Demographics: Most employees are aged 35-44, followed by those aged 45-54. 58% have worked for their employer for two (2) years or less, while 15% have been with the agency for more than 10 years.

Pay: The majority earn between $18-$19 per hour, and 26% earn $16-$17 per hour.

Agency Tenure: 30% of QSP Agencies have been operating for less than a year. 21% have been in business for 1-3 years, and 27% for over 16 years.

Client Load: 54% of QSP agencies serve 0-9 clients, while 18% serve 10-19. Only 12% of agencies serve more than 30 clients.

Service Provision: 66% of agencies provide all services they are enrolled for, while 19% are enrolled to provide service they are not currently offering.

Benefits: Over 50% offer benefits like paid vacation, health, dental, vision insurance and retirement plans.

Capacity and Staffing: 63% of agencies have capacity to serve more clients, and 55% feel adequately staffed. However, 35% say they are understaffed. 92% are willing to take on more clients if adequately staffed, and 65% plan to expand, mainly by increasing staff and their service area.

Hiring Process: 35% say it takes 1-3 months to hire new staff, 26% say 1-3 week, and 9% can hire in under a week.

Recruitment Tools: The top recruitment tool is compensation/pay, followed by flexible work schedules, simpler paperwork, responsive support, benefits, help with onboarding, and payer reimbursement.

Employee Retention: Compensation/pay is also the top factor in retaining employees, followed by flexible schedules, benefits, advertisement opportunities, continuing education, and payer reimbursement.

Reasons for Employee Departure: 90% of agencies say employees leave for higher paying jobs, followed by jobs with better benefits, and more family-friendly hours.

Training: The majority of QSP agencies are interested in learning about managing the claim process, followed by marketing services, and staff management.

QSP Enrollment Portal Data

In Year 4 of the SA, the State transitioned the QSP enrollment process in-house, assigning state staff the responsibility for enrolling and revalidating QSPs. In January 2024, an online QSP portal was launched to streamline enrollment, gathering all required data through a guided series of questions. The portal assesses the qualifications of applicants, suggesting services for which they are eligible and then automatically enrolling them. This helps providers understand their full-service capacity. This recruitment strategy reduces the need for providers to request additional services post-enrollment because they were initially unsure what services to choose.

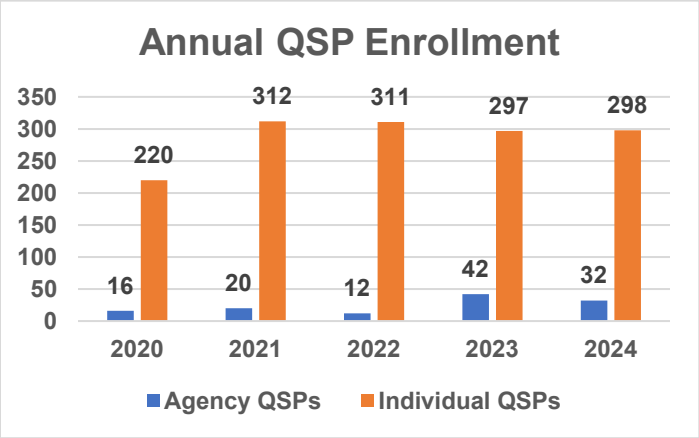
To improve access to HCBS, another goal was to process completed applications within 14 days. In the first three (3) quarters of Year 4, average QSP approval time was reduced to just 10 days. Previously, enrollment via paper applications could exceed 90 days.

The QSP Enrollment Portal has improved the number of applications that are approved on the first submission. Enrolling providers quickly is essential, especially when TPMs will need care as soon as they discharge from the hospital or SNF. This is even more important when a family member becomes the primary caregiver. In these situations, family members often face the difficult choice between providing care to a loved one and staying in the workforce. Timely reimbursement for authorized care is very important to prevent family caregivers from losing their income. This support enables them to help an eligible family member live safely in the community with the necessary care.

The QSP Survey ranked streamlined certification high on the items that were important for provider retention. The QSP portal will also be used for the revalidation process, where QSPs will demonstrate ongoing competency. Each enrolled QSP has an account created in the system and must log in to claim their account and set a unique password. The revalidation process mirrors initial enrollment, guiding QSPs intuitively through each step. Recent changes in the ND Administrative Code require QSP agencies to

revalidate every five (5) years instead of every two (2), while individual QSPs must demonstrate competency every 2.5 years and fully revalidate every five (5) years.

There are several metrics the State uses to determine if the strategies they are using are effective in recruiting, enrolling, and retaining QSPs. One metric is QSP enrollment numbers. The chart below illustrates the number of new agencies and individual QSPs enrolling each year. The number of new agencies enrolling increased by 163% from 2020 to 2023. Twenty-six (26) of these new providers have enrolled to provide residential habilitation and community support services which is important because they can offer up to 24/7 support for TPMs who have a lot of complex needs. The growth in this type of provider is due in part to the State helping to pay for CQL accreditation and offering QSP incentive grants to start and expand new agencies. Both were strategies that have proven to be successful. Four (4) new agencies were started using QSP Incentive Grant funds and all but one (1) of the residential habilitation and community support providers were assisted with paying for their CQL accreditation.

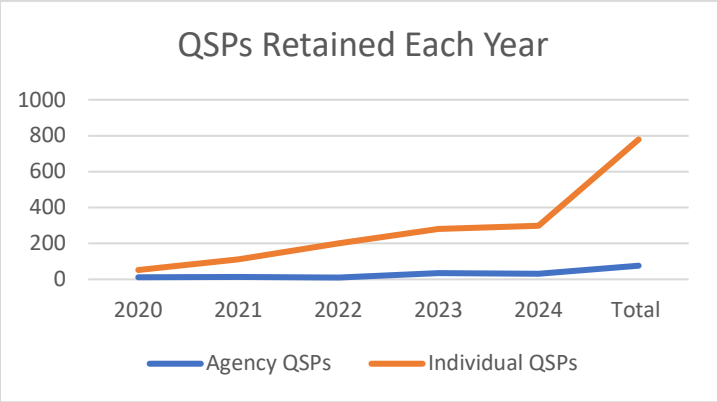


Another important metric in evaluating impact to the system is annual QSP retention. Over the past four (4) years, the State has made substantial investments to enhance systems and streamline processes for QSPs, supporting both care delivery and reimbursement. These improvements include a new case management system enabling QSPs to acknowledge service authorizations and submit claims electronically, based on actual hours worked. QSPs can now bill multiple times each month, improving cash flow and their ability to cover payroll. An update to the system also introduced electronic documentation for direct care professionals, ensuring all required data elements are recorded and securely stored. These enhancements support compliance, aid internal audits, and reduces potential financial takebacks due to documentation errors, which has been common in the past.

The following chart shows the upward trend in QSP retention of new providers. With the State on track to retain a high number of QSP agencies in 2024, like 2023, these retention numbers indicate sustained provider engagement and the more efficient reimbursement for services rendered. This suggests that the State's investments in

system improvements have had a positive impact on the Home and Community-Based Services system.

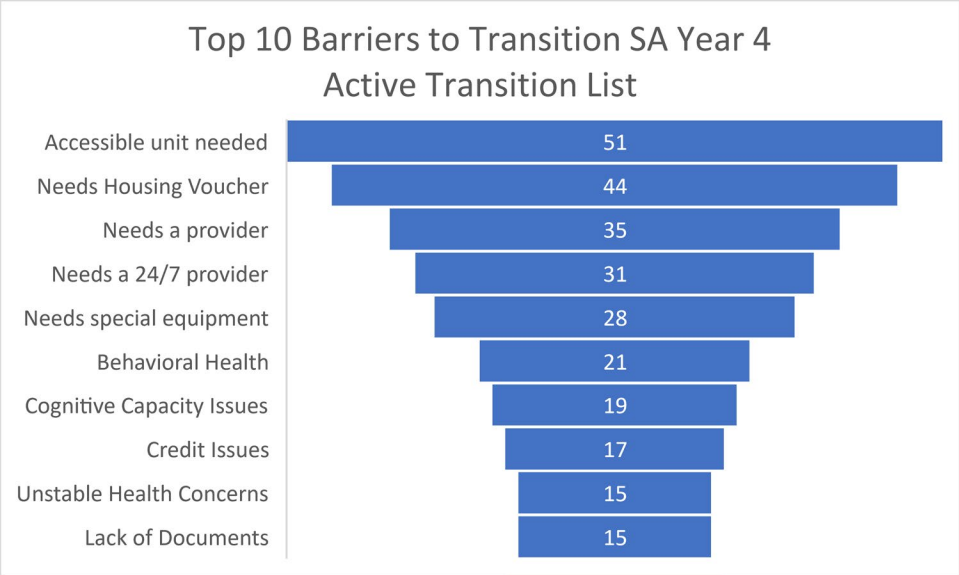
New QSPs Retained by Year	2020	2021	2022	2023	2024	Total
Agency QSPs	11	14	10	34	32	76
Individual QSPs	52	112	201	280	298	779



TPM Transitions

In recent updates to the SA the State is required to identify at least two (2) strategies for transitioning TPMs whose transitions have been pending for more than 100 days. See the strategies in SA Section XI. B. that address this requirement. The strategies identify the specific barrier(s) to transition that the strategy is designed to address, how the State will implement the strategy, any data that will be collected or analyzed as part of the strategy, and how the State will determine whether the strategy successfully results in TPMs transitioning from a nursing facility to the community. In Year 4 of the SA, 95 TPMs had a staff review of their case because they had been waiting to transition back to the community for more than 90 days. The State tracks the trends that are identified during the staffing with the hopes of proposing new strategies that will assist TPMs in moving back to the community in a timely and safe manner. This analysis does not reflect individuals who indicated an interest in transitioning and were on the active transition list, but whose transitions were later categorized as inactive.

The Chart below illustrates the most common barriers. TPMs may experience more than one transition barrier.



Housing remains the number one (1) barrier to community living. Federal Housing regulations are very complicated. For example, Housing and Urban Development (HUD) federal housing assistance policy for the Mainstream Vouchers has recently changed. It is now possible for anyone with a disability under age 62 years in America to request a housing voucher from the ND Housing Authorities. The only way to keep Mainstream Vouchers in ND is for the Housing Authorities to update their policies and create memorandums of understanding (MOUs) with entities like the Department of Health and Human Services (DHHS) to create a priority list for local citizens and develop a separate waiting list for Mainstream Vouchers. The process to create MOUs with DHHS has begun.

There are also long wait lists for other types of assistance like Housing Choice Vouchers. For example, the waitlist in Fargo is closed and they estimate about a four (4) year wait between applying and receiving a Housing Choice Voucher. These issues make the need for other rental assistance funds even more important. For this reason, the State is requesting to use Money Follows the Person (MFP) supplemental services funding to assist with the first six (6) months of rent. If rent is needed after six (6) months, the MFP rebalancing rental assistance program will be used to ensure the TPMs still have access to accessible and affordable housing. The State will also use any State-funded rental assistance that may be appropriated in the 25-27 DHHS budget.

In the early years of the SA, finding a provider for TPMs in the community was a significant challenge. Although this issue still exists in some parts of the state, it's now less prevalent. The numbers in the chart above may be misleading, as only two (2) TPMs currently face delayed transitions due to a lack of available providers. The other TPMs will eventually need providers, but their searches haven't yet started because they are still waiting for housing. The State plans to update data collection methods in future reports to include only individuals who are actively searching for a provider.

There are currently four (4) HCBS recipients who already live in the community who are looking for a QSP in the towns of Mandan, Mohall, and Minot. The challenge now is more nuanced as it can be hard to find qualified providers in certain parts of the State. In some areas, like Fargo, providers are waiting for referrals due to the high number of home care agencies competing for HCBS recipients. Currently, Fargo has 81 QSP agencies enrolled to offer personal care services. However, the State does not have enough HCBS referrals to supply each agency with a steady stream of new clients. To address this, the State is working with these providers to explore options such as hiring staff in underserved areas, relocating staff willing to move, or traveling to these communities to earn the higher rural differential rate.

Behavioral health needs for TPMs can be challenging, especially when issues related to mental health or substance use create difficulties in securing and retaining a QSP. In some cases, TPMs may jeopardize their services by refusing to work with caregivers from another race, being highly demanding, or maintaining an unsafe home environment. To address these challenges, the State plans to provide specialized training to supervisory staff from 26 adult residential and community support providers currently enrolled. These providers were chosen because they frequently work with TPMs who have high acuity and complex needs. The training, delivered by an agency experienced in community-based mental health, will focus on de-escalation techniques and building personal resilience.

Issues relating to a TPMs decision making capacity are also emerging as a barrier to transition. In some cases, a TPM's guardian or legal decision-maker may oppose the transition. In other cases, the TPM does not have a legal decision-maker, but their transition team may have questions about whether the individual fully understands what a community move involves or what it means to sign essential legal documents like a lease. In those cases, care teams often request a capacity assessment, and a delay in transition may occur. The State is committed to further addressing the issues that may arise regarding a person's decision-making capacity and reducing barriers to transition. The State plans to create a workgroup and invite external stakeholders like the Guardianship Association, Protection and Advocacy, Brain Injury Network and the LTC Ombudsman that will make recommendations for handling these situations in the future. These recommendations may lead to new strategies in the IP.

Access to the right durable medical equipment (DME) is critical for TPMs to transition successfully and receive care in the community. However, transitions are sometimes delayed due to incorrect equipment orders or delays in placing orders, resulting in equipment not being available on the discharge date. To address this, the state is working with facilities to improve discharge planning and providing training for MFP Transition Coordinators on the Medicaid DME approval process, helping ensure the correct equipment is ready by the discharge date.

Another challenge many TPMs face is unstable health conditions. Setbacks can occur when a new diagnosis or health emergency arises while a TPM is waiting to transition. To address this, transition teams will continue strengthening relationships with hospital

and SNF staff, maintaining open lines of communication to support and update transition plans affected by TPMs' health concerns and new discharge dates.

Another, less common but important, issue is that some TPMs lack personal identification, birth certificates, and other essential documents required to secure housing and other community services. To address this, the Housing Facilitation Assessment completed by the Housing Facilitator will be updated to verify if TPMs have these documents during the initial eligibility meeting. If they lack the necessary paperwork, the transition team will begin the process of obtaining these documents right away, so the process does not slow transitions.

Outcome of Systems Change

Evidence of real system change is clear when looking at the number of individuals in North Dakota who have been diverted or transitioned from more costly and restrictive levels of care. The State has also expanded knowledge of and access to HCBS, as shown by the increased contacts with the Aging and Disability Resource Link (ADRL) and LTSS Options Counseling (LTSS OC). The data below reflects the impact of the first 3.75 years of the Settlement Agreement.

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

- **1,214** new TPMs diverted from a SNF by providing necessary services and supports so they can remain at home with their family and friends.

- Provided State or federally funded HCBS to **3,143** unduplicated adults in 2021; 3,189 in 2022; **3,368** in 2023; and **3,391** to date in 2024.

- Shifting to centralized intake using the ADRL website and a toll-free phone line linking people with disabilities to HCBS support allowed the State to substantially increase the ability to provide information and assistance and help people apply for HCBS.

    - ADRL staff answered **53,269** calls for information and assistance about HCBS and responded to **4,464** web referrals for HCBS.

- Connecting TPMs in hospitals and SNFs who were referred for a long-term stay at a SNF and providing them with information about HCBS, person-centered planning, and transition supports significantly increased the number of referrals to the MFP program. In Year 4 of the settlement agreement there have been 142 referrals made by SNF staff and 80 referrals made by the LTSS Options Counselors.

    - LTSS OC staff provided information about HCBS options during **16,874** visits to TPMs referred for a long-term stay in SNF.

- Implementing a transition team that includes the HCBS case manager, MFP transition coordinator, and the housing facilitator has improved the relationships between State and contracted staff and improved the quality of the transition planning for TPMs returning to an integrated setting.

- Adding community support services and residential habilitation to the 1915(c) HCBS Medicaid waiver service array and paying for the Council on Quality and Leadership (CQL) accreditation for Agency QSPs helped recruit more Agency QSPs willing to enroll to provide these important 24-hour alternatives to institutional care. This strategy allowed TPMs with some of the highest care needs to safely transition from SNFs to the most integrated setting.

    - **Twenty-six (26)** Agency QSPs were successfully enrolled as residential habilitation and community-support providers.

- The COVID-19 pandemic and corresponding federal relief funds **increased both the demand for HCBS** and the resources available to provide them. Although some of the demand for HCBS **increased because of the pandemic** health and visitation restrictions in SNFs, the trend has continued post-pandemic. The referrals to HCBS continue to remain high.

IP Performance Measures and Benchmarks

The following is a summary of Year 4, 5 and 6 benchmarks identified in the SA.

By December 13, 2024

- **Transition 60% of TPMs** who are **requesting transition** from skilled nursing facilities**.** SA, *Section XI, E. (2b)*

    - **Continue to ensure** that transitions occur **no later than 120 days** after the member chooses to pursue transition to the community. *SA, Section XI, E. (2a).*

    - **Divert an** additional **150 at-risk TPMs** from SNFs to HCBS. *SA, Section XI.E. (2b)*

    - Provide permanent **supported housing** to TPMs based on aggregate need. *SA, Section XII, B(1d).*

    - Conduct individual **in-reach to 1,000 TPMs** residing in SNFs. *SA, Section XIV.A.(1).*

- Submit a **biannual data report** to the USDOJ and SME. *SA, Section XV. D.* This report is submitted within a reasonable timeframe after the end of the reporting period.

- Additional 650 TPMs receive person-centered planning and a PCP. Half need to be TPMs residing in a SNF. *SA, Section VIII. I. (3).*

- Updated implementation plan addresses allocating resources sufficient to assist with permanent supported housing. *SA, Section XII. B.*

By December 13, 2025

- Submit two **biannual data reports** on February 1, 2025 and August 1, 2025 to the USDOJ and SME. *SA, Section XV. D.* This report is submitted within a reasonable timeframe after the end of the reporting period.

- Submit Year 6 IP by November 1, 2025.

By December 13, 2026

- Additional 670 TPMs receive person-centered planning and a PCP. Half need to be TPMs residing in a SNF. *SA, Section VIII. I. (3).*

- Transition 70% of TPMs who are requesting transition from skilled nursing facilities. SA, *Section XI, E. (2b).*

- Divert an additional 150 at-risk TPMs from SNFs to HCBS. *SA, Section XI.E. (2b),* so that a total of at least 400 at risk TPMs will have been diverted since the Effective Date.

    - **Update IP** to ensure **transitioning or diverting** from nursing facilities to **community-based services** all remaining TPMs whose **PCP** indicates now or in the future that transition, or diversion is appropriate and unopposed. The Plan will address transitioning members within 120 days from when the member chooses to pursue transition and diverting members in time to avoid unnecessary nursing facility stays.

Year 5 Priorities

During Year 5 of SA implementation, additional key strategies will need to be implemented or finalized to ensure the upcoming Settlement Agreement benchmarks are met and system change efforts are successful. They include:

- Increasing the direct care workforce and improving the QSP experience by continuing to improve the systems implemented to help QSPs with provider enrollment, revalidation, claims submission, and documentation of services provided. This will include:

    - Finalizing the Connect to Care marketing features.

    - Collaborating with the QSP Hub to design the right type of training, support, and professional development opportunities to retain and

attract QSPs especially in “service deserts” to meet the growing demand for HCBS.

- Collaborating with stakeholders and industry leaders to find ways to identify and recruit traditional and nontraditional providers willing to expand their business model to include the provision of HCBS.

- Connecting and recruiting family caregivers who initially enrolled to serve a relative but may be willing to serve as a caregiver for other members of their community.

- Reducing the administrative burden of individual QSPs. The State will continue to consider other provider models and the feasibility of including formal self-direction policies in the HCBS system.

- Continue to monitor the capacity of case management, transition coordination, and housing facilitation to meet the continued demand for HCBS. Continue to improve and develop the reporting and data collection process to implement the required activities of the SA and effectively use data to assess HCBS service quality and outcomes.

- Use all available Federal and State resources to provide permanent supported housing opportunities to TPMs so they can live in the most integrated setting appropriate.

    - Focus on ensuring TPMs have continued access to rental assistance, environmental modification, and consider how we can incorporate handy man services into the current service array.

- Provide behavioral health supports and training for QSPs. Consider creating a behavioral health endorsement for QSPs who are willing to be trained in this area. Consider value-based rates that allow providers who have earned the endorsement to receive a higher rate for services provided to TPMs.

- Continue to work with Native American stakeholders and other special populations to improve awareness and increase access to culturally informed HCBS. Continue to support the development and growth of Tribal owned QSP agencies.

- Continue to prioritize timely, efficient, and safe transitions for TPMs that are completed within the 120-day benchmark required in the Settlement Agreement.

- Work on quality assurance projects that improve how HCBS are delivered statewide.

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)**

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 stakeholder meetings through Year 5 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

Updated Strategy 2. The State will host eight (8) in-person meetings in rural, frontier, and Native American reservation areas of North Dakota to discuss Home and Community-Based Services (HCBS). These sessions, distinct from DOJ stakeholder meetings, aim to assess existing services and address unmet HCBS needs, especially in underserved areas. Meetings will offer information on HCBS, provider enrollment, and gather local feedback to guide improvements. Event dates will be posted on the DHHS website, and a year-end feedback summary will inform future service enhancements. Invitations will be extended to local hospitals, skilled nursing facilities, social services, community leaders, and advocates. **(Target completion date December 13, 2025)**

Updated Strategy 3. Include representation from New Americans, Native Americans and other special groups when gathering public input. The State will work with the Developmental Disability Section, Department's refugee services coordinator, University of North Dakota (UND) Native American Resource Center, staff from Tribal entities, the Interim Executive Director of the ND Human Rights Coalition, and other advocates from the LGBTQIA+ community to determine the best way to reach these populations and gather input that will improve access to HCBS. These groups will also be consulted to help identify local subject matter experts who may be willing to provide cultural awareness training with State staff and providers.

The State will also continue to work with the UND Native American Resource Center staff to hold a monthly stakeholder call with experts from Tribal entities to work on HCBS initiatives that will positively impact Tribal communities. **(Ongoing Strategy)**

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

Implementation Strategy

Agreement Coordinator will meet weekly with the SME and team to consult on the 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.

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 employs HCBS case managers who 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 provides ongoing training and professional development opportunities to include cultural awareness training for special populations to ensure a high-quality trained case management workforce. The State continues 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 have been developed. **(Ongoing strategy)**

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

Updated Strategy 2. The State has two (2) FTE that serve as provider navigators who will assist all HCBS case managers statewide in finding QSPs to serve eligible HCBS recipients. The State is considering the feasibility of using the new Connect to Care system, formally referred to as ConnecttoCareJobs platform, to share referrals for HCBS to QSPs. Assistance from the provider navigators frees up time for the case managers and assists them in keeping up with the increased demand for HCBS. **(Target completion date August 1, 2025 and ongoing)**

New Strategy 3. There has been a large increase in the number of QSP Agencies that have enrolled to provide services, especially in Fargo, ND. This has made the desire for new referrals in that area very competitive. To ensure an equitable opportunity for QSP Agencies to respond to new referral requests, the State implemented a QSP referral policy. The State has distributed the policy and will be holding a virtual stakeholder meeting to provide education about the process and gather feedback that will inform any necessary policy updates. Link to Provider Navigator – Frequently Asked Questions (FAQs) (**Stakeholder meeting complete December 31, 2024)**

Updated Strategy 4. 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 74 licensed social workers currently hired as HCBS case managers. The State has plans to add four (4) additional nurse case managers in early 2025 and to add one (1) additional Basic Care Case Manager. **(Target completion date April 1, 2025 and ongoing)**

New Strategy 5. The State has established a workgroup consisting of HCBS Case Management Supervisors and Aging Services Program Administrators to analyze the business process of entering all required information into the State's case management system. The goal of this review is to identify steps that may be delegated to administrative support staff thus freeing up time for the HCBS Case Managers to focus on client facing duties. If enough administrative tasks are identified, the state will consider the feasibility of hiring administrative support for the HCBS Case Managers. **(Target completion date April 1, 2025 and ongoing)**

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)**

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 twice increased the number of case managers available to serve this population and continues to monitor the need for additional staff.

Remediation

The State continues 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)**

New Strategy 2. The State is taking steps to stop charging eligible individuals a service fee for case management. Instead, we will request to claim Federal Medical Assistance Percentage funds (FMAP) to cover the cost of providing case management to Medicaid-eligible individuals receiving Medicaid HCBS. The State has submitted a Medicaid waiver amendment to make this change and is working on similar adjustments for Long Term Care Targeted Case Management (LTC TCM). This shift is expected to increase federal funding, which may be used to hire additional case management and potentially support staff to meet the growing demand for these services. **(Target completion date April 1, 2025 and ongoing)**

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)**

Updated Strategy 2. Conduct training with hospital and SNF staff to discuss HCBS, LTSS OC, 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 Nursing Facility Level of Care (NF LoC) process and to address any emergent issues and may be provided virtually. The Year 5 focus will be to help these entities understand the need to make referrals as soon as possible to facilitate safe discharge and access HCBS the first day they return home. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

Training will be held at least biannually in Year 5 of the Settlement Agreement. One (1) of the trainings will be held virtually. **(Target completion date December 13, 2025)**

Strategy 3. Utilize the educational materials created to inform TPMs, family, and legal decision makers of the requirements of the SA, LTSS OC, ongoing case management for SNF TPMs, and that TPMs must complete an annual NF LoC determination. **(Ongoing strategy)**

New Strategy 4. 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 for which they may qualify. 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. If a TPM seeks more information about the services administered by Adult and Aging Services, the DDPM conducting the intake will transfer the call to the ADRL team, who will provide additional details and start the intake process. 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 DD individual service plan for individuals and guardians to sign, confirming receipt of this information.

Adult and Aging Services staff will provide training to DD Program Managers including the supervisors in February 2025 about the Adult and Aging Services HCBS system.

The DD section will also conduct quarterly quality checks of twenty (20) cases to ensure that eligible individuals are receiving information about the state's HCBS coverage, both initially and annually thereafter. This process will begin in Oct 2025, using data from July 1 - Sept 30 2025. **(Target implementation date July 1, 2025)**

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

Updated Implementation Strategy

Provide HCBS case managers and relevant State agencies and contractors access to all case management tools including the HCBS assessment and PCP. Continue to contract with a vendor to maintain and enhance the case management system that was fully implemented August 1, 2022. State staff meet weekly with the vendor and have a list of enhancements that will be implemented during Year 5 of the DOJ SA. Current simplification projects include updating the PCP into one document to reduce duplication and data entry time and meet requirements of the federal HCBS Quality Measure Set. **(Target completion date December 13, 2025, and ongoing strategy)**

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, risk assessment, 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 specific to TPMs. **(Ongoing strategy)**

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.

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

Number of people from the DD waiver requesting information about the Aging Services HCBS system.

Number of referrals to the Aging Services HCBS system from the DD waiver.

DDPM's understanding of HCBS options after February 2025 training.

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Updated Implementation Strategy

- See Section VIII, Subsection H (Ongoing strategy)

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

Updated Implementation Strategy

Every PCP will incorporate all the required components as outlined in Section VIII.C.1-8 of the SA and these are apparent in PCP documentation. The PCP tool in the case

management system will allow all required information to be captured and included in the plan. The PCP will be updated every 6 months, annually and 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.

The new federal HCBS Quality Measures will require the State to modify parts of the PCP. The State will review any proposed changes to the PCP with the SME before changes are implemented. **(Target completion date May 1, 2025 and ongoing)**

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)** See Section XI, Subsection B, new strategy 6 for additional information.

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.

SME review of transition plans (Section VIII, Subsection G, page 13)

Implementation Strategy

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)**

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

Updated Implementation Strategy

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 will be 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.

In 2025, the State will implement the "Train the Trainer" portion of the curriculum throughout Aging Services. The State is considering using federal ARPA 9817 10% 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 in the Indicators of Competency and Evaluating Competency in Person-Centered Planning. **(Updated target completion date December 31, 2025)**

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

Implementation Strategy

Updated Strategy 1. 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. The State continues to complete person-centered planning with TPMs as required. There is no specific PCP benchmark for Year 5. By the end of Year 6 of the SA the State must conduct person-centered planning with an additional 670 TPMs.

Strategy 2. Ensure that a PCP is completed with every TPM who requests HCBS and is still residing in the community. **(Ongoing strategy)**

Strategy 3. 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.

New Strategy 4. To help ensure that New Americans, Native Americans, and members of other minority groups have equitable access to HCBS, the State submitted a waiver amendment to Centers for Medicare and Medicaid Services (CMS) to add care coordination as an allowable task under HCBS case management. The provider qualifications were also updated to expand the types of Tribal entities and other culturally informed agencies that can provide this service and takes into consideration lived experience. TPMs who are at risk of losing their service provider or who would benefit from access to care coordination provided by an individual who shares their culture or native language will be eligible for this service. **(Estimated waiver approval date is January 1, 2025 and the service will be ongoing.)**

HCBS Care Coordination services will include:

- Identifying needs and locating necessary resources to establish or

maintain a stable and safe living arrangement.

- Coordinating, educating, and linking individuals to resources.
- Providing and establishing networks of support.
- Assisting with necessary paperwork and documentation to help gain access to services will ensure a stable and safe living environment and,
- Assisting with the development of the PCP.

New Strategy 5. The State is collaborating with Economic Assistance and the integrated eligibility system named SPACES vendor to generate a report. The report will help identify people who have submitted pending Medicaid applications, ensuring that the State is aware that they are TPMs who need options counseling. Aging Services staff do not have direct access to this information due to the confidentiality rules, and the report will bridge the gap connecting Medicaid data with the daily list of individuals with approved NF LoCs. **(Estimated completion date January 31, 2025.)**

Updated Strategy 6. The State with the help of subject matter experts designed one of the person-centered planning competency modules to address cultural humility and competency. As of November 2024, all Aging Services staff will be trained and required to meet these competency standards annually. New staff must complete the training within 12 months of their hire date. **(Ongoing strategy)**

Updated Strategy 7. Ensuring access to interpretive services and translating informational materials into other languages.

The QSP enrollment portal will include tool tips in Spanish, French, Nepali, 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 January 1, 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.

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

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

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

Number of unduplicated PCPs completed for TPMs in the community.

Number of unduplicated annual PCP visits to TPMs in SNF.

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

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS Adults and Aging Services

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

Implementation Strategy

Updated Strategy 1. The State compiled 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. The State will implement any of the new services and projects included in the Executive Budget Request if they are approved during the 2025-2027 Legislative session. **(Funded services will be known by June 1, 2025)**

Updated Strategy 2. The State is still considering using presumptive eligibility to assist Medicaid applicants in accessing HCBS. The Agreement Coordinator has had ongoing conversations with the Medical Services Director, other states, and CMS. Recently, CMS issued new guidance on the use of presumptive person-centered plans of care, which could help TPMs access HCBS more quickly. The new guidance may have a similar effect of helping eligible TPMs to gain access to HCBS quickly. The State will continue discussions with stakeholders on how to best implement this in ND. **(Target completion date June 30, 2025)**

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 UND. 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.

Of the 31 Agencies that were enrolled as a QSP as of September 30, 2024, 52% or (16) of the agencies received technical assistance from the QSP Hub. Of the 267 individuals enrolled during this same period 30% (80) of these new providers received technical assistance from the QSP Hub. 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. **(Ongoing strategy funded through September 2025)**

Updated Strategy 2. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will determine the feasibility of implementing any changes to the provider model or include formal self-direction policies in the HCBS waiver and Medicaid State Plan – Personal Care programs. If a decision is made to adopt this model, we would request Legislative appropriation during the 2027-2029 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 will also consider the significant investment in creating systems to improve the QSP enrollment experience completed over the past few years to make the final decision. System investments include the QSP Enrollment Portal, QSP registry ConnecttoCare, free access to electronic visit verification (EVV) and the documentation and billing submission system. These investments have shifted much of the administrative burden off the providers. **(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)**

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

Implementation Strategy

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)**

Updated 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**.**

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. If approved, case managers will no longer need to request a modification of policy for this purpose because it will become a permanent part of the service. **(Estimated completion date January 1, 2025 and ongoing)**

1. Allow a Registered Nurse (R.N.) 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.

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

- See 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 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 in US DOJ SA Year 5 with paying for their CQL accreditation. **(The State has funding available through June 30, 2025 or until funds are expended.)**

The State enrolled seven (7) QSPs to provide these services so far in 2024. The State provided funds to pay for CQL accreditation to six (6) agency QSPs. Three (3) of the agencies have been enrolled and three (3) are working on accreditation and are on track to be enrolled soon. Paying for initial CQL accreditation has been an effective strategy for recruiting QSP agencies. There are currently 27 community support and 25 residential habilitation providers enrolled. As of September 30, 2024, 69 TPMs are receiving 24-hour supports using these services.

Updated Strategy 2. Continue to use the rate augmentation fund to reimburse providers for additional expenses incurred while delivering authorized services to HCBS recipients. These additional funds can cover costs such as employee travel, training, and employee wait time between serving clients. The fund may also offer incentives for Agency QSPs to pursue additional staff training in caring for individuals with dementia, TBI, or behavioral health issues. Additionally, the funds can be used to contract professionals to develop individualized program plans that mitigate known risk while supporting clients in the most integrated environment. The primary requests that have been made to this fund are requests to pay for supplies to complete chore services, and requests to pay a second provider to assist with physically demanding care like transfers, or for two (2) staff to be in the home to ensure the providers safety. **(Ongoing through October 31, 2025)**

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

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 February 1, 2025 and on-going)**

Updated Strategy 4. 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 with high need/high complexity cases, and offering consultation to in-home providers as needed. The State is working with the Behavioral Health Division to identify providers in ND who already provide this service. Provider agreements will be established with qualified entities and training will be conducted with the HCBS Case Managers, so they know how to access these services. **(Target completion date January 1, 2025 and ongoing)**

Updated Strategy 5. 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 behavioral health and substance use disorders. Representatives from each of these areas are participating in person-centered planning team meetings and developed a set of goals and training expectations for providers.

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 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)**

Updated Strategy 6. The State will work with behavioral health subject matter experts to create a process for community support and residential habilitation agency QSPs to earn 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 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. **(Target completion date December 13, 2025 and ongoing)**

New Strategy 7. The State will work to procure a vendor that could teach motivational interviewing to Aging Services staff and the management staff of QSP agencies that are enrolled to provide residential habilitation and community supports. **(Target completion date July 1, 2025)**

New Strategy 8. The HCBS Program Administers and HCBS Case Management Supervisors will be meeting regularly with the Statewide Human Service Center Administrator who is a Licensed Psychologist to discuss current needs and trends being identified by HCBS staff and ways that the State's Behavioral Health System can collaborate to meet the needs of this growing population. **(Started October, 2024 and ongoing)**

Updated Strategy 9. 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.

Another resource QSPs can use is the 988 Suicide and Crisis Lifeline funded by the Substance Abuse and Mental Health Services Administration. This service is available across the United States and offers 24/7 call, text and chat access to trained crisis counselors who can help people who are experiencing suicidal, substance use, or other mental health crisis or emotional distress. This service is provided via contracted providers in North Dakota and is a direct connection to immediate support and resources for anyone in crisis. **(Ongoing Strategy)**

New Strategy 10. The State intends to convert every Regional Human Service Center to become a Certified Community Behavioral Health Clinic (CCBHC). This model is designed to ensure access to comprehensive behavioral health care. CCBHCs are required to serve anyone who requests mental health or substance use treatment, regardless of their ability to pay, where they reside, or age. CCBHCs are required to get people into care quickly and must provide: 24/7 crisis services, comprehensive services that reduce the need for multiple providers, and care coordination to help people navigate health care, social services, and other systems. The Behavioral Health Division will be requesting legislative authority to develop state certification during the upcoming Legislative session. Considering other regulatory timelines, the first clinics should be able to apply for certification late spring/summer 2026.

Staff from Aging Services will be meeting with the clinical director of the HSC quarterly to talk about common cases and the issues TPMs face in accessing quality behavioral health services. Additional IP strategies will be created as we collaborate more with the Human Service Center leadership.

Section IX. Performance Measure(s)

Number of QSPs offering on-call services.

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

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

Number of TPMs receiving extended personal care.

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

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

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

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 OC 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)**

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 OC 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, Developmental Disability, 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)**

Updated 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 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)**

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

Implementation Strategy

The SME drafted a Diversion Plan during the first year of the SA as required with input and agreement with the State. The State implemented or has incorporated recommendations included in the Diversion Plan in the last four (4) years. The SME was not required to write updated plans and now makes recommendations to the state in the SME compliance report and during weekly meetings with the State. Therefore, the SME Diversion Plan is no longer included as an appendix to the IP.

Link to October 2024 SME Report

Section X. Performance Measure(s)

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

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

Number of unduplicated annual PCP visits to TPMs in SNFs.

Number of cases staffed per interdisciplinary team meetings and outcomes.

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. 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)**

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. Began contact monitoring and can see where guidance is needed in each region.

- 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 significant enough problems are found, CILs will be required to submit a corrective action plan that is approved by the State to mitigate the issues.

- CIL transition coordination contracts require the CILs to attempt to hire additional staff to meet the demand for transition coordination in their service territory.

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 continuously gathers input from stakeholders and transition coordinators to design and implement additional supplemental services to assist TPMs in transitioning to the community. **(Ongoing Strategy)**

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 (pending means from date of signed consent) 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)**

Updated 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.

Of the 75 completed transitions in the first six (6) months of Year 4 4 69% of TPMs were transitioned within 120 days or less. Thirty-one (31%) percent took longer than that. TPMs who transitioned using the Transition and Diversion Services Pilot Project (TDPP) were all transitioned home in 60 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 more successful. 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.

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. 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 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. The strategies are contained throughout this section.

2024 Top 10 Barriers to Transition	N=95
TPMs on 90+ day Active Transition List	
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
Cognitive Capacity Issues	19
Credit Issues	17

Unstable Health Concerns	15
Lack of Documents	15

New Strategy 3. Recent changes to HUD rules and other challenges have made accessing federal housing assistance increasingly difficult, highlighting the growing importance of State-funded housing resources. To maximize the use of federal rental assistance, the State plans to request the use of MFP supplemental services funding to cover rent for TPMs for up to six (6) months. If further support is needed beyond this period, State-funded rental assistance will cover the remaining costs. This strategy, contingent on CMS approval, requires the development of a CMS approved, individualized housing plan. Additionally, a TPM rental payment agreement must be signed to ensure TPMs understand their responsibility for paying their portion of the rent. This agreement clarifies program expectations and helps TPMs better understand the MFP benefits they receive. The State tracks the number of TPMs who receive State or federally funded rental assistance. The goal of this strategy is to reduce the number of TPMs waiting for affordable and accessible housing and to decrease the number of days it takes to transition. **(Estimated completion date July 1, 2025)**

Updated Strategy 4. Addressing the issue of finding a provider, especially one available 24/7, ranks high on the list of the most common transition barriers. However, these numbers can be misleading because in most cases, the transition coordinators don't start searching for a provider until the housing issues are resolved. The State will change the way we track future data and will not include finding a provider as a barrier unless providers are actively being sought. Many TPMs needs can be met through residential habilitation and community support providers and there are 26 providers currently enrolled to provide these services. However, many of them are limited to serving people in the Fargo area. The State will continue to offer assistance for obtaining initial CQL accreditation for up to five (5) additional agencies who want to enroll to be residential habilitation and community support providers**.** The State will track the actual number of TPMs who are waiting to transition because they can't find a provider and the number of Agency providers who have been assisted to enroll. **(The State has funding available to assist with CQL accreditation through June 30, 2025 or until funds are expended.)**

- Section IX Subsection H updated strategy 1 also applies to this section.

New Strategy 5. To address the barrier of TPMs not receiving the correct durable medical equipment (DME) upon discharge from a SNF, the State is collaborating with facilities to implement a targeted solution. Certain aspects of discharge planning are best managed by facility staff, including securing the necessary doctor's orders for DME to ensure the TPM's safety after discharge. However, delays often occur when facilities do not promptly order the equipment or fail to submit insurance claims in a timely manner.

To enhance the understanding of the DME process among MFP staff and empower them to advocate effectively for the required equipment, the Medical Services Program Administrator for DME conducted a training session. MFP staff received guidance on DME eligibility and authorization processes and were encouraged to reach out to the Program Administrator directly if they encounter issues with DME approvals.

The State anticipates a reduction in errors related to DME access and will monitor and address this issue, reporting results in future semiannual updates. **(Training completed on October 16, 2024, ongoing strategy)**

- To address the barrier of behavioral health challenges please see Section X, Subsection B updated strategies 3, 4, 5 and new strategies 6, and 8.

New Strategy 6. Transition teams may have questions about whether a TPM has capacity to consent to receive MFP transition supports. The transition team's first step is to send a letter to the SNF to determine if any advanced directives are in place and to understand how the TPM consented to care in the facility. In some cases, the TPM has a legal decision-maker who does not support the TPMs transition plan. The transition team uses a person-centered approach to mediate conflicts and, when a guardian has decision-making authority over the individual's healthcare and residence, their consent is required for the transition to happen. If needed, a neutral third party may be involved to facilitate resolution.

In other cases, a TPM has no legal decision-maker and can legally give consent to transition. But there may still be concerns regarding transition: for example, finding housing can be challenging, if landlords are reluctant to rent to an individual who they feel may not understand the legal obligations connected with signing a lease or a TPM's transition may be delayed while they are waiting for a capacity determination.

To address these issues, the State plans to collaborate with Legal Services of ND, Protection and Advocacy, and other stakeholders to explore solutions. These may include identifying mediators, training peer supports as supportive decision-makers, and developing resources to educate TPMs about their rights to make their own decisions and what steps to take if they feel their guardian is not respecting their needs and preferences. The State will track meeting dates and suggested recommendations for the development of future strategies that will be added to the IP. The State will draft educational materials and track the number of TPMs who were assisted in advocating for their right to live in the community and the outcomes of any third party or peer support attempts to mediate these situations that led to successful transition. **(Target completion date to draft recommendations, educational materials, and assignment of third neutral third party/peer support August 1, 2025)**

New Strategy 7. To address credit and personal finance barriers due to not paying bills, bad debt, and difficulty budgeting money. TPMs will who have this issue listed as a barrier will be referred to take the SmartwithMyMoney.nd.gov program. Link to website This free website allows individuals to create an account, take a research-based

financial personality assessment, and learn how their personality affects their money decisions. The program also seeks to improve financial knowledge by providing information on key topics designed to help people make sound financial decisions. The site offers personalized learning resources to improve financial literacy. The State will track the number of TPMs who complete the training and then became eligible to get assistance with paying their previous debt to remove the barrier. **(Implemented August 2024 and ongoing)**

New Strategy 8. To address the barrier of missing essential documents such as a State identifying document (ID) or birth certificate required for federal housing and other assistance, the Housing Facilitation Referral assessment will now ask if they have a valid ID, birth certificate, and proof of citizenship status. If any documents are missing, Housing Facilitators and Transition Coordinators will immediately begin assisting them in obtaining these, reducing the chance of transition delays. **(Estimated implementation date January 1, 2025)**

Updated Strategy 9. 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 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. **(Target completion date is April 1, 2025)**

New strategy 10. Deciding to move from a SNF and back into the community is a significant decision. Some TPMs have not lived independently, managed a household, or been responsible for tasks like paying bills, buying groceries, or maintaining utilities for a very long time. Additionally, TPMs might worry about accessing necessary care and living without 24-hour in-person support, even if they no longer require that level of care. These concerns can lead to hesitation or uncertainty about transitioning, and it may take time for them to fully consent to a move.

Some TPMs may struggle to identify exactly what's holding them back from setting a transition date and may benefit from talking to individuals with lived experience who can guide them through the process. To support this, the State will pilot a peer support program using individuals already trained to provide peer support in ND. TPMs who have been waiting to transition for six (6) months or longer will be offered an opportunity to work with a peer support provider. This will give them a chance to explore, their thoughts, address their concerns and make a more informed and timely decision about community living. The State will track the number of TPMs who are using peer support

and if the service helped them come to a decision about transition. **(Target implementation date January 1, 2025)**

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

Updated 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 OC 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 up to one (1) year post discharge. The HCBS case manager also provides ongoing case management assistance.

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. **(Ongoing strategy)**

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

Updated Implementation Strategy

Strategy 1. By December 13, 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)**

New Strategy 2: A barrier to community living for some TPMs is the difficulty of securing enough direct support staff, particularly when their physical needs require more than two (2) caregivers to ensure safety during intermittent care that is needed throughout the day. To address this issue, the State will authorize assistive technology assessments to determine if equipment could reduce the need for human assistance. Additionally, the State is exploring remote monitoring solutions to potentially decrease reliance on multiple caregivers, offering TPMs more care options and greater

independence. **(Ongoing strategy, target completion date for a decision about remote monitoring solutions August 1, 2025)**

Updated Strategy 3. The QSP Hub will 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. **(Target completion date December 13, 2025**)

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)**

Section XI. Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

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

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

Number of referrals for peer support, outcome, and satisfaction survey.

Number of TPMs who use alternative rental assistance and successfully transition to the community.

Number of TPMs who transitioned with alternative rental assistance and are still living in the community 1 year after transitioning.

SA Section XII. Housing Services

Responsible Division(s)

DHHS

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

The SME drafted a Housing Access Plan during the first year of the SA as required with input and agreement from State. The State implemented or has incorporated recommendations included in the Housing Access Plan in the last four (4) years. The SME was not required to write updated plans and now makes recommendations to the State in the SME compliance report and during weekly meetings with the State.

Therefore, the SME Housing Access Plan is no longer included as an appendix to the IP.

Link to October 2024 SME Report

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

Implementation Strategy

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

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.

Remediation

Housing case notes were added to the case management system. One case note identifies housing barriers upon referral and the second 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.

New Strategy 2. During the first few years of the Settlement Agreement the State formed an Environmental Modification workgroup to improve North Dakota's approach to home modifications. This group focused on identifying barriers faced by TPMs as outlined in their PCPs and while providing transition and diversion services. A key barrier identified was the shortage of construction and remodeling contractors willing to enroll as a QSP, and the challenge of securing deposits or partial payments for materials before the work could begin.

To address this, the State received approval from CMS to use $300,000 of State only rebalancing funds, to initiate and complete home modifications for individuals eligible for home modification through the HCBS waiver or through State funded HCBS. This service is specifically for those not receiving MFP. MFP participants already have access to this benefit without facing the same claims payment issues.

When an environmental modification project is approved for an eligible individual and no provider is available, the State's designated assistive technology provider, a local non-profit organization and Agency QSP will act as the intermediary. They will subcontract the work and pay contractors in installments using this fund. The non-profit will oversee project completion, manage payments through the Medicaid Management Information

System (MMIS) and receive an overhead fee for managing the project. Once the overhead fee is deducted, the remaining funds will return to the pool for future use. If the eligible individual passes away or the project is not completed, the fund will bear the cost. The MFP Program Administrator will oversee this contract to ensure the proper use of funds and that they are returned upon project completion. The goal of this initiative is to help more TPMs remain in their homes by making them safe and accessible for necessary care. **(Estimated implementation date February 1, 202**

New Strategy 3. When landlords notify Housing Facilitators about an available accessible apartment for rent, the facilitators will begin tracking this information to match available housing with TPMs waiting to transition. The total number of accessible units will be reported in both the MFP and DOJ semiannual reports. This tracking helps pinpoint unit locations, fosters stronger relationships with landlords, and enables Housing Facilitators to efficiently connect TPMs and MFP recipients with suitable housing options. **(Implemented October 2024 and ongoing)**

Updated Strategy 4. Convene quarterly 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)**

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

Implementation Strategy

Updated Strategy 1. Complete and maintain a housing coordinator crosswalk to identify the entities that offer housing facilitation and what type of supports they offer to ensure everyone is aware of the parameters of each program. The intent is to avoid duplication and understand the eligibility of each program to facilitate appropriate referrals. **(Target completion date December 31, 2024 and ongoing)**

Updated 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 Collaborative established the following goals and is creating 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 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.

New Strategy 3. The rules governing HUD Mainstream Vouchers have recently changed. It is now possible for anyone with a disability under age 62 years in America to request a housing voucher from the ND Housing Authorities. To ensure that HUD Mainstream Vouchers are available for TPMs living in ND, the State is working with the eight (8) ND Housing Authorities to update their policies and create MOUs to establish a priority list for local citizens and develop a separate waiting list for Mainstream Vouchers. **(Estimated completion date December 31, 2024)**

New Strategy 4 To increase access to resources to provide environmental modification to TPMs already living in the community, the Rehab Accessibility Program (RAP) administered by the ND Housing Finance Agency will update the amount of funds available to pay for renovations from $5,000 to $7,000 per person. The $300,000 fund allows unspent dollars to carry over each year through Federal Fiscal Year 2029. The fund offers grant dollars for the renovation of properties occupied by lower-income North Dakotans with physical disabilities. Examples of qualifying renovations include the installation of ramps, door levers, walk-in/roll-in showers, grab bars and the widening of doorways. **(Estimated completion date June 1, 2025)**

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

Implementation Strategy

Updated Strategy 1. Develop training for housing facilitators 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 the new Home Modification Capital Fund, 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)**

Updated Strategy 2. 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

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 staff, 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)**

New Strategy 3. The MFP Housing Facilitators offer Tuesday Trainings with MFP on housing related topics. The trainers are local experts that discuss housing related issues in ND. The target audience is service providers and landlords, 700 people have registered for these events. The trainings are recorded and shared so they can be used as an ongoing resource. **(Ongoing Strategy)**

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)**

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

Implementation Strategy

Updated Strategy 1. Expand permanent supported housing capacity by funding and providing rental subsidies for use as permanent supported housing. The State will provide rental assistance with any State funds that may be appropriated during the 2025-2027 Legislative session. **(Target appropriation effective date July 1, 2025)**

Challenges to Implementation

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

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

Section XII Performance Measure(s)

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

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

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

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

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

Number of environmental modifications completed using rebalancing funds.

Increase in the total number of environmental modification projects.

Decrease in the amount of time it takes to complete environmental modification projects.

Amount of money remaining in the Environmental Modification fund at the end of the State Fiscal Year.

Number of landlords who contact Housing Facilitators about available accessible units.

Number of TPMs who are matched with accessible housing through housing facilitation.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

All the strategies in this section are meant to improve provider recruitment, enrollment, and retention, and enhance quality and professionalism of QSPs. Each strategy will state the intended outcome and the state plan for collecting and analyzing data.

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

Implementation Strategy

Updated 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, EVV, billing, and business operations to recruit and retain a sufficient number of QSPs. This includes 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.

Intended Outcome: Provide support and technical assistance to agency and individual QSPs to boost enrollment and improve retention rates.

Data: The State will use data from the QSP Enrollment Portal to monitor and analyze trends in QSP enrollment and retention. Additionally, the State will track the number of agency and individual QSPs who received technical assistance from the QSP Hub who successfully enrolled as providers.

New Strategy 2. The 2024 QSP Annual Survey revealed that 30% of individual QSPs who expressed interest in additional training specifically requested education on various diseases and medical conditions. In response, the State will collaborate with the QSP Hub and other qualified entities to find training tools and live events to enhance QSP knowledge in this area. Potential topics include schizophrenia, bipolar disorder, dementia, traumatic brain injury (TBI), stroke, multiple sclerosis, and Parkinson's disease. **(Ongoing strategy funded through September 2025)**

Intended Outcome: QSPs will receive requested training and gain increased knowledge of common diseases and medical conditions.

Data: The State will collect training data, including attendance numbers and pre- and post-test results to assess learning outcomes. Responses to this question will also be tracked in the 2025 QSP Annual Survey.

New Strategy 3. The 2024 QSP Annual Survey indicated that most QSP agencies requesting training need support in business acumen, particularly in managing the claims process, followed by marketing services and staff management. To meet these needs, the State will collaborate with the QSP Hub to provide targeted training. The QSP Hub will produce service-specific claims videos that guide users through each step of service authorization and claims submission, aimed at helping new users get started after enrollment. Additionally, the State will involve Medical Services claims staff and the billing system vendor to offer comprehensive claims training. The QSP Hub will also create specialized training focused on marketing strategies for small business **(Ongoing strategy funded through September 2025**)

Intended Outcome: QSPs will receive requested training and gain increased knowledge of various business acumen topics.

Data: The State will collect training data, including attendance numbers and pre- and post-test results to assess learning outcomes. Responses to this question will also be tracked in the 2025 QSP Annual Survey. The QSP Hub will be asked to track and trend the number of calls to the Hub related to these topics after training is provided.

Updated Strategy 4. 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)**

> **Intended Outcome:** Healthcare students will complete internships in QSP agencies, gaining HCBS experience that can lead to employment opportunities and increased access to HCBS.
>
> **Data:** The QSP Hub will track the number of internships established and the number of students who were retained by the agency or indicated interest in pursuing future work in the in-home and community-based services field.

Updated Strategy 5. Implement any legislatively approved rate increases for specific HCBS that may be approved in the 2025-2027 DHHS budget. **(Appropriation effective date July 1, 2025)**

> **Intended Outcome:** Services with a rate increase may attract additional providers, thereby expanding access to HCBS.
>
> **Data:** The State will track the number of QSPs enrolled to provide the service before the rate increase and monitor changes in enrollment after the increase to assess impact.

Updated Strategy 6. Continue to operate the online provider enrollment portal for agency and individual QSPs. The system is used for initial QSP enrollment, revalidation, and maintenance of provider information and service array information. **(Ongoing strategy)**

> **Intended Outcome:** Complete enrollment and revalidation of completed QSP applications within an average of 14 days after submission.
>
> **Data:** The State will use enrollment data to track the average enrollment and revalidation dates from the QSP Enrollment Portal to assure timeliness in processing.

Updated Strategy 7. 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 is available to HCBS case managers and others online. It allows 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)**

> **Intended Outcome:** QSPs will be able to effectively use the system to market their services to HCBS recipients and the public thus increasing access to HCBS and reducing the number of providers requesting referral and marketing assistance from the QSP Hub.
>
> **Data:** The State will track the number of QSPs using the system that choose to update their provider profile as a way of marketing their services. The QSP Hub will track the number of calls they receive regarding a lack of referrals and marketing experience.

Updated Strategy 8. The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population in "service desert" 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. **(Updated Target completion date August 1, 2025)**

> **Intended Outcome:** Increase the number of traditional healthcare providers and SNFs enrolling as QSPs, thereby enhancing access to HCBS, especially in hard-to-serve area of the State.
>
> **Data:** The State will track the number of healthcare providers and SNFs that inquire about providing HCBS after the letter is sent, as well as monitoring data to determine how many ultimately enroll and begin providing services.

Updated Strategy 9. To facilitate timely transitions for TPMs who live in areas where QSPs are hard to find, the State will support TPMs or their chosen QSP agency in using targeted marketing strategies to recruit staff. Funding will be made available to create job descriptions and post advertisements on social media and other platforms, highlighting specific individuals' needs. TPMs can choose to include details about the type of care required or the specific qualities they are seeking in a provider. This personalized approach aims to attract applicants motivated by a desire to helping others and support individuals with disabilities in community living. **(Target implementation date November 1, 2024 and ongoing)**

> **Intended Outcome:** Recruit individuals willing to provide care to TPMs waiting to

transition due to a lack of available providers or staff in their chosen community. Reduce the number of TPMs waiting for a provider to facilitate their transition from a SNF to the community, and decrease the total time required to complete TPM transitions.

Data: The State will track the number of providers recruited, the number of TPMs who ultimately transitioned home, and the number of days to transition in situations where this marketing strategy was used.

New Strategy 10. Support start-up and enrollment activity costs for existing QSPs to establish or expand their ability to provide non-emergency medical transportation, non-emergency medical transportation escort, 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)**

Intended Outcome: Increase access to transportation and community integration services by providing grants to QSP agencies for purchasing accessible vehicles.

Data: Increase the percentage of HCBS recipients who report that transportation is not a barrier to accessing the community, as measured in the 2025 National Core Indicators for Aging and Disability (NCI-AD) survey.

Updated Strategy 11. To continue to ensure timely enrollment and revalidation of QSPs, the State will continue to keep QSP enrollment duties inhouse. The State hired five (5) temporary QSP enrollment staff that work under the supervision of the Medical Services QSP Enrollment Coordinator. Staff use the QSP portal to compete all aspects of QSP enrollment. QSP enrollment staff are also responsible to manage the Connect to Care QSP registry, which interfaces with the QSP portal to ensure provider information is accurate and up to date. The QSP enrollment staff will also use the system to process provider revalidations and manage provider data. **(Implemented January 03, 2024 ongoing strategy)**

Intended Outcome: The goal is to process all new QSP enrollment and revalidation applications within 14 calendar days of receipt of a complete application.

Data: The average number of days of enrollment is tracked in the QSP Enrollment Portal.

Updated Strategy 12. Continue to 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 expected 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.

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 their 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 is currently drafting a Request for Purchase (RFP) to revise the current training for HCBS providers across the lifespan. Future drafts of the IP will contain strategies to implement the training recommendations including the possibility of offering scholarships to providers to encourage participation. **(Target completion date September 01, 2025)**

Intended Outcome: Increase access to HCBS by simplifying the training requirements need to enroll as a provider serving multiple populations.

Data: Track the number of providers trained and enrolled to provide care across various populations, including Aging Services, Developmental Disabilities, and Behavioral Health.

Updated Strategy 13. 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 former 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. Now that the new QSP enrollment portal is complete, State staff will work with the QSP Hub staff to design an effective outreach campaign to attempt to retain QSPs who originally enrolled to serve a family member or friend. QSPs in areas of the State that lack sufficient QSPs will be targeted. The State will target QSPs that disenrolled in the past six (6) to nine (9) months and were in good standing with the DHHS will be targeted for this project. 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. **(Target Completion Date March 1, 2025)**

> **Intended Outcome:** Increase access to HCBS by recruiting former QSPs in good standing to become providers again.
>
> **Data:** Track the number of providers who re-enroll and the number of HCBS recipients they subsequently serve.

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 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)**

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

Implementation Strategy

The SME drafted a Capacity Plan during the first year of the SA as required with input and agreement from the State. The State implemented or has incorporated recommendations included in the Diversion Plan in the last four (4) years. The SME was not required to write updated plans and now makes recommendations to the state in the SME compliance report and during weekly meetings with the State. Therefore, the SME Capacity Plan is no longer included as an appendix to the IP. Link to October 2024 SME Compliance Report

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

Implementation Strategy

Updated Strategy 1. 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 and 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.

The State holds monthly meetings with a group of subject matter experts with representation from each Tribal nation in ND to address the outstanding in-home and community-based service needs of Tribal members. The group is currently implementing the plan to improve access to care coordination and culturally informed Long-Term Care Targeted Case Management (LTC TCM) services. The next project will focus on the implementation of the HCBS access rule. **(Ongoing Strategy)**

Updated Strategy 3. 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)**

Updated Strategy 4. 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. **(Ongoing strategy through December 2025)**

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

- QSP Rate Augmentation Fund
- Peer Support 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

Section XIII. Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

Number of QSP agencies receiving CQL accreditation.

Number of new agencies enrolled as providers.

Number of agencies that stopped providing services.

Number of new individual QSPs enrolled as providers.

Number of individual QSPs that stopped providing services.

Rate increases effective January 1, 2024.

Number of QSPs trained to Connect to Care system formally referred to as ConnecttoCareJobs by February 29, 2025.

Number of SNFs that have 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)

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, 2025 and ongoing)**

Updated 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 ask the nursing home to complete an SFN 584 form, and then the ADRL staff will send the referral 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. 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.

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 originally admitted to the 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. **(Ongoing strategy)**

Challenges to Implementation

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 OC will continue to provide written information and their contact information during their initial and annual visits and will be required to document in the care plan that the individual was provided this information.

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 OC 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)**

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

Updated Implementation Strategy

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 5 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 SNF admissions, such as geriatricians and 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, 2025)**

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

The State will continue to 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 received June 2021. **(Ongoing strategy)**

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 SA 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)**

Section XIV. Performance Measure(s)

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

Number of TPMs who requested and received a communication accommodation.

Number of TPMs who access respite and the hours provided.

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, 2025, and ongoing strategy)**

Updated Strategy 2. 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 totaled 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 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 (2) 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 (2) 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 that shows that only 55% of the units authorized were used. This number seems very low considering the number of individuals who request homemaking services 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%

The State is currently collaborating with the case management vendor to develop a custom report that compiles all service authorization numbers within designated provider groups. This report will then be compared with service authorization numbers in the MMIS system to identify which ones are part of a group. Any discrepancies will be flagged for the research team at UND, allowing them to assess the authorized service amounts against the actual services delivered—ensuring accuracy and preventing inflated reporting of authorized units.

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 December 1, 2024).**

Updated Strategy 3. Implement an interface with the Vulnerable Adult Protective Services (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. **(Estimated completion date August 1, 2025)**

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 ND DOJ SA. Key Performance Indicators are reported quarterly. **(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. Number of QSP agencies enrolled as providers.
10. Number of individual QSPs enrolled as providers.
11. Number of QSP retained.
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.

Section XV. Performance Measure(s)

Number of service units authorized and utilized by county.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

Updated Implementation Strategy

The SME drafted a Safety Assurance Plan during the first year of the SA as required with input and agreement from the State. The State implemented or has incorporated recommendations included in the Safety Assurance Plan in the last four (4) years. The SME was not required to write updated plans and now makes recommendations to the state in the SME compliance report and during weekly meetings with the State. Therefore, the SME Safety Assurance Plan is no longer included as an appendix to the IP.

Relink to the current SME report on the ND webpage that has them all.

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 VAPS 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 American Rescue Plan Act (ARPA) funding for VAPS. **(Target implementation date February 1, 2025)**

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

Implementation Strategy

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 the QSP orientation that is now required as part of QSP enrollment. Training is 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)**

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)**

Updated 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 assigned one of the nurse administrators to be responsible for providing technical assistance to QSP Agencies to help them implement robust QI programs. State staff have reviewed all current QSP QI programs for compliance. When a QI program does not meet standards, the State provides 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.

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 and the survey will be completed again starting January 2025. The State reviewed the results of the study and collaborated 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 are 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)**

New Strategy 4. The 2023 NCI - AD report shows that 25% of TPMs on the HCBS waiver have had a history of at least two (2) falls in a six-month period and another 10% did not know or were unsure of their fall history. Aging Services CIR data shows that there were 54 falls reported in 2024 involving TPMs. Many of the falls happened in memory care facilities resulting in emergency room visits via ambulance. To reduce falls amongst TPMs, Aging Services staff will work with the memory care facilities to implement one of the evidence-based falls prevention programs offered under the OAA Title III-D Preventive Health program. Staff at participating memory care facilities will be trained to offer the fall prevention classes for free and will incorporate the classes into their resident activity programs with the goal of reducing fall related CIRs from this population. **(Target implementation date July 1, 2025)**

New Strategy 5. The 2023 NCI - AD report shows that 15% of survey participants stated that they lack transportation to get to medical appointments, and 6% of the Medicaid State Plan - Personal Care participants stated they do not have transportation to get to medical appointments. The State's CIR data shows that TPMs went to the emergency room 309 times so far in 2024. Sometimes TPMs use the emergency room even when the medical need is not really an emergency. One reason for this may be because it can be difficult to find a non-emergency medical transportation provider and the authorization process is not efficient. The State has already modified the QSP enrollment portal to allow individual and agency QSPs to enroll as a non-emergency medical transportation provider making getting access to a provider easier. The next step is for Aging Services staff to work with the Medical Services Division to improve the authorization process to make it easier for TPMs to access this important service. **(Estimated completion date September 1, 2025)**

Updated Strategy 6. 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. The SA was updated on August 29, 2025 to streamline the types of incidents that must be sent to the USDOJ. 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.

Strategy 7. An Aging Services nurse administrator is responsible to work with State staff to implement the HCBS Quality Measure Set as identified in State Medicaid Director letter (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 MFP program. Initial data collection needs to start in 2025 to be reported in 2026. The State has begun the process of implementing these measures and regularly attends training provided by CMS. Aging Services staff will be responsible for training state staff and QSP on the details of the measures and their intended use. **(Ongoing Strategy)**

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**.**

To ensure timely reporting the DHHS Aging Services conducts critical incident reporting required trainings for QSPs. Training is provided quarterly through online modules and virtual training events. The QSP handbook includes current reporting requirements and critical incident reporting requirements are included in the QSP orientation that is 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. **(Ongoing strategy)**

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)**

Strategy 2. The DHHS Adult and 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, VAPS staff, LTC Ombudsmen, and the DHHS risk manager. **(Ongoing strategy)**

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)**

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)**

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

Implementation Strategy

Updated 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 VAPS 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)**

Updated 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 and is considering options to fund an additional FTE to be allocated to Aging Services. 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)**

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 Medicaid Fraud Control Unit (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 is also 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. The orientation was implemented in January 2024 and will be periodically reviewed and updated. **(Ongoing Strategy)**

New Strategy 5. To build relationships and improve quality, Aging Services Program and Nurse Administrators are meeting with the leadership of all residential habilitation and community support agencies to discuss program requirements, roles, and responsibilities of HCBS Case Managers and QSP Agency staff, and expectations for providing quality care and incident management. These meetings have been well

received and the Nurse Administrators will soon begin meeting with Extended Personal Care Nurses to improve communication and consistency of this important program. **(Estimated completion date December 13, 2025)**

Section XVI Performance Measure(s)

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

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

Number of critical incident reports that have an associated complaint.

Number of amendments reported.

Number of TPM complaints and outcomes.